2001 HIV Prevention Program Meeting
"Year One Implementation of the Health Department Evaluation Guidance:
Lessons Learned and Lessons from the Field"

June 18 - 21, 2001
Atlanta, GA

Summary Proceedings

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Monday, June 18, 2001

On Monday, June 18, 2001, Health Department Guidance 101 Training took place, and registration began for the actual 2001 HIV Prevention Program Evaluation Meeting.

The actual deliberations of the training session were not captured. However, there were handouts and other collateral materials which may be referred to for an overview of the content of the presentations.

Plenary sessions were convened on both June 19th and June 20th, though not all were captured in their entirety. In addition to the full assembly coming together during the 19th and 20th, they also convened into smaller groups to deliberate specific topics.

For ease of reading, and given that some groups were convened twice but on different days, the reports of all concurrent sessions have been combined, and follow the plenary session report of Wednesday, June 20, 2001.

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Tuesday, June 19, 2001

Opening Plenary and Concurrent Session Information

The 2001 HIV Prevention Program Meeting was convened on Tuesday, June 19, 2001. Carl Hill, Centers for Disease Control and Prevention (CDC), moderated the Opening Session. Robert Janssen, CDC, and Lynne Greabell, National Alliance of State and Territorial AIDS Directors (NASTAD) delivered the welcoming remarks. The following presentations were delivered:

Status Report

❏   Marlene Glassman, CDC
     Evaluation Guidance Updates

❏   Choi Wan, CDC and
     Xen Santas, CDC
     Evaluation Reporting and Analysis System

Keynote Address

The keynote address was delivered by Laura Leviton of the Robert Woods Johnson Foundation (RWJ).

Concurrent Session One

❏   Translation Issues/Taxonomy
❏   Intervention Quality/Scientific Basis
❏   Data Collection, Reporting, and Quality Assurance
❏   Translation Issues/Translation Interventions

Concurrent Session Two

❑ Translation Issues/Taxonomy
❑ Intervention Quality/Scientific Basis
❑ Data Management
❑ Translation Issues/Translation Interventions

2001 HIV Prevention Program Evaluation Swap Meet

On the afternoon of June 19, 2001, meeting participants engaged in the *2001 HIV Prevention Program Evaluation Affinity Swap Meet*. The HIV Prevention Program Evaluation Affinity Swap Meet afforded health department jurisdictions and others the opportunity to share innovative tools, documents, and processes with their colleagues. Health departments have worked very hard to develop evaluation tools and user friendly evaluation methods for their health department staffs, community based organizations, and community planning groups in order to implement the evaluation guidance.

There is a need to ensure that the successes of one can be shared by all. Each health department that participated in the Swap Meet sent a representative who was present during the entire session to exchange ideas, answer questions, and provide meeting participants with copies of great materials. The HIV Prevention Program Evaluation Swap Meet was a special time to "shine" for those who give countless hours and hard work in program evaluation and the fight against the epidemic. Participating health departments showcased materials on the following topics:

❑ Data Collection and Reporting
❑ Outcome Evaluation/Outcome Monitoring
❑ Data Management
❑ ERAS: Questions and Answers and Demonstration
❑ Intervention Plan Reports

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Opening Plenary Session

Gary Uhl, Moderator
Centers for Disease Control and Prevention

Gary Uhl welcomed the participants to the final day of the meeting. He explained that the plenary session would include an open forum for health departments to react to the Health Department Guidance.

He then described an ongoing project being conducted in the Program Evaluation Research Branch at CDC. This project is an assessment of the evaluation capacity of health departments funded for HIV prevention, with St. Louis University as a contractor and various other collaborators involved as well. The project has three main purposes which are to:

❏   Get a better understanding of what health departments are doing related to program evaluation;

❏   Collect models of successful approaches that health departments have used to evaluate their HIV prevention programs; and

❏   Make recommendations to CDC from health departments that reflect what they need to conduct program evaluation better.

Gary Uhl indicated that an expert panel, comprised of representatives of health departments and specialists in program evaluation and capacity-building from across the country convened in Atlanta to inform the program on the appropriate research questions and data-analytic methodology. CDC chose the case study approach for the project because it is highly exploratory and flexible. That approach will also highlight the different contexts of how health departments conduct evaluation in their jurisdictions. Six health departments have been invited to participate in the project. Site selection was based on a variety of factors, including HIV/AIDS disease burden and racial and ethnic and cultural diversity.

Data collection will begin in Atlanta with a review of all existing documents from these six sites all over the country. On-site visits will include structured interviews with health department evaluators, AIDS program directors, and other health department program staff. Because of their methodology, case studies will help highlight the strengths and challenges of each health

department individually and in an aggregate sense. The information gathered will help CDC learn what health departments need to conduct program evaluation better. Specific recommendations in the report will include:

❏   Health departments' descriptions of needed financial and other resources for evaluation capacity;

❏   What health departments need regarding training and technical assistance needs; and

❏   Technology needs.

The report is expected to be completed in early winter 2002, and it will be shared widely with health departments across the country and to the division at CDC. The program evaluation assessment will include broad activities, not just those included in the Evaluation Guidance.

Marlene Glassman
Centers for Disease Control and Prevention
Impact of the HD Evaluation Guidance

Marlene Glassman spoke of an ongoing project with ORC MACRO on assessment of the impact of CDC's Evaluation Guidance on health departments and their grantees. They also worked with a panel of experts. The evaluation design incorporates a case-study approach in six different health department jurisdictions. Qualitative and quantitative data will be collected, and ultimately will be analyzed to assess how planning and programming have changed as a result of implementation of the guidance. Unintended consequences will also be explored.

Initial positive impacts identified by the expert panelists and other health department staff included:

❏   Enhancing intervention planning
❏   Revised RFP's on intervention quality
❏   Adding CDC taxonomy so that there is standardization in reporting
❏   Raising the level of the quality of interventions
❏   Enhanced quality of interventions in general
❏   Enhanced communication between health department grantees and community planning groups
❏   Enhanced data collection and management of information systems
❏   Integration of CDC, state, and other evaluation requirements
❏   Enhanced understanding of, and commitment to, evaluation

Identified challenges in Guidance implementation included:

❏ Scarcity of staff and resources to carry out evaluation and to implement the Guidance
❏ Capacity-building in evaluation as well as data collection and management, client tracking, and other areas
❏ Securing buy-in from grantees
❏ Translating local definitions into the Guidance taxonomies and populations and interventions
❏ Mechanisms for client tracking
❏ Collecting and managing data

There are a great deal of impacts that have come about as a result of the Guidance, Dr. Glassman concluded, and they look forward to sharing the information that they gather.

Charles Collins
Centers for Disease Control and Prevention
HD Evaluation Guidance TA

Charles Collins reflected on the previous comments of Laura Leviton concerning the imperfect data received from Medicaid. The lesson from the Medicaid experience was that data that is not used drifts and may not be valid when needed. He urged the participants to make sure their data are solid so that they can be used to improve their programs, and he discussed the issue of inflation of outcome indicators.

When CDC began providing technical assistance to different jurisdictions regarding the Evaluation Guidance, they had two goals which were to:

❏ Be customer-oriented and to answer the questions that needed answering; and
❏ Ensure that they were building evaluation capacity.

A three-person team worked in technical assistance. Of the 65 funded health departments, 58 of them requested technical assistance. The questions that came in fell into one of five broad categories:

❏ Interpretation of the guidance
❏ Data collection and management, how to collect and report data from CBO's
❏ Behavioral science theory and intervention issues
❏ Local diffusion, training, and buy-in
❏ Outcome evaluation

One of the major lessons learned from their technical assistance experiences was the need for software for data management. Charles Collins acknowledged that CDC should have given health departments software a year previously, and he stressed that they had learned from this mistake. With that in mind, the upcoming CBO Evaluation Guidance will include adequate software up-front.

In the area of behavioral science, their most-asked question was, "At what point does street-level outreach become an individual-level intervention?" From the definitions in the Guidance, they are able to say, "Ensure that there is a skill component and individualized risk assessment." It became evident from the questions that CDC heard that they should move toward creating intervention standards. Different states are establishing intervention standards for their CBOs, and unless the CDC works together with the states, there will be 65 different standards for behavioral interventions.

There were a variety of questions in the category of outcome evaluation, from questions about appropriate interventions to design questions. Charles Collins thought the most interesting questions regarded ethical and appropriate comparison groups. Health departments informed CDC that community-based organizations will not use wait-list or no-treatment control groups.

From communicating with health departments, Charles Collins and the technical assistance team learned that there is a need for evaluability assessment techniques, "How do you choose the interventions that are the best candidates for your outcome evaluation?" There is a need for continued technical assistance as the health departments continue to develop, implement, and assess outcome evaluations.

In conclusion, Charles Collins assured the participants that CDC will remain available for this assistance, and will work together with departments to discover whether the programs work, and how to improve them.

Gary Uhl then turned the participants' attention to the Open Forum Session. This session was moderated by Randy Pope of National Alliance of State and Territorial AIDS Directors (NASTAD).

Open Forum Discussion on the HD Evaluation Guidance

Randy Pope, Moderator
National Alliance of State and
Territorial AIDS Directors (NASTAD)

Randy Pope introduced the panel which included: Robert Komescher, Chalres Collins, Marlene Glassman, Gary Uhl, and Deputy Chief of the Program Evaluation and Research Branch of CDC, Bob Moran.

Before beginning the session, Randy Pope announced the formation of a web-based listserv to communicate about evaluation issues created by Jim Luther, and which is as follows:

> subscribe: evaluationguidance-subscribe@yahoogroups.com
> web: http://groups.yahoo.com/group/evaluationguidance

Randy Pope indicated that the panel would welcome questions of a broad range, including evaluation in general, the future of the Evaluation Guidance, and any other issues. He explained that the opportunity for open dialogue with colleagues at CDC is an important part of the fight against the AIDS epidemic.   He then introduced David Napp who acted as facilitator for the group, who first set the ground rules and then opened the floor for discussion.

Discussion Summary:

❖ An inquiry was posed as to whether CDC had begun a discussion, or come to any conclusions about, what portion of grant awards should be dedicated to various components of evaluation, to data collection, to capacity-building, etc. Also asked was whether there would be technical assistance to grantees as movement was made toward standardized approaches (e.g., Will there be any funds to support it?).

❖ Marlene Glassman replied that CDC had not discussed additional funding. She reminded the group about the supplemental funding that is available for evaluation. She stressed that how that is parceled out among the various activities is left to the discretion of the health departments. Charles Collins added that many questions have centered around whether health departments can purchase computers for CBO's that do not have them as part of evaluation capacity-building. He said that they could do so.

❖ Gary Uhl added that the Cooperative Agreement had not specified what proportion of funds should or could be used for evaluation. He wondered whether it was possible with these prevention dollars to designate a percentage for evaluation overall, and then individually for different tasks. He suggested that it would be a topic worth discussing as the next Cooperative Agreement was created. Bob Moran commented that serious discussions would begin in January, 2002 and that issue would be part of the deliberations.

❖ Charles Collins was asked what role he envisioned for CDC Prevention Training Centers for grantees and subcontractors in the area of behavioral science, particularly given the comment that behavioral interventions had not been evaluated or emphasized.

❖ Charles Collins responded that training in the Guidance had been conducted for health departments when the Guidance was distributed a year previously. This meeting is the first "booster session" for the training. Before this meeting, they received calls from six health departments indicating that the staff who had gone through the initial training were no longer working with them. Regarding the Prevention Training Centers, their goal is that they use the same language as the Evaluation Guidance. He acknowledged that CDC had been criticized for being slow at diffusing behavioral interventions into the field. Therefore, a major initiative has been included in the current year budget. The AIDS Community-Based Demonstration Project is one of the four interventions that will go into the field first. He stressed that CDC is committed to community-level interventions.

❖ It was noted that the case studies in evaluation capacity would be helpful if they included descriptive information about the exact evaluation questions states are asking and their methods. Sharing of basic ideas could be done via conferences and phone calls as well.

❖ Gary Uhl responded that the study of the six health departments' evaluation capacity would include specific, successful strategies and models that the departments use for HIV prevention program evaluation. The ensuing report will detail successful approaches. Marlene Glassman commented that the other study on the impact of the Guidance is not designed to yield details on how the Guidance is being carried out; however, they are developing a resource manual with examples of evaluation strategies. Bob Moran added that sharing creative approaches in a timely way is an important part of what CDC can do.

❖ Regarding the issue of outcome evaluation and monitoring, a participant noted that CDC was revising those guidelines and pointed out that outcome monitoring fit into the logic model of most community-based agencies which "bought into" the technique. There are ethical issues, but the results can build capacity.

❖ Marlene Glassman answered that reconciling the issues with outcome evaluation has

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presented the opportunity to talk with NASTAD and health departments to re-frame requirements and to put emphasis on outcome monitoring. Outcome monitoring often yields immediate results for the community-based organizations, said Charles Collins, which can lead to program improvement and motivation to continue.

❖   Gary Uhl added that the Evaluation Guidance started four years ago, and there were suggested requirements in the initial document. As the process was built on consensus, and because of space considerations, that chapter was not considered to be a requirement. With regard to the new Cooperative Agreement, there will be discussions about whether including outcome monitoring for health departments is appropriate.

❖   Lisa Randall, from Michigan, commented that her department had spent a great deal of time and expertise setting the parameters for evaluation, which is important. She asked what sort of consideration CDC is giving to some concrete and technical guidance, and for support around actually using the evaluation. She pointed out that there was not much discussion about how the data that they are generating will be used for program management at the state level, or to improve the quality of programs at the local level.

❖   Marlene Glassman agreed, pointing out that they have conducted a number of sessions at various conferences about use of data, and that there is a chapter on that topic in the resource manual. She said they should consider other ways to convey the message of the utility of data and how it can be used to improve planning and programs.

❖   Charles Collins added that using the data means it is continually improved. The capacity-building branch has learned that training is needed in how to use data for program improvement. ORC MACRO is helping them design a curriculum around the use of data for program improvement. When the curriculum is created, there will be three pilots to test it, and then it will be distributed. The technical assistance system needs to focus on this topic as well, he said.

❖   It was noted that the focus of the Evaluation Guidance, and of the data being collected, should be on use and the utility of that data The questions asked around evaluation drive the data variables. There are different purposes for different audiences. In preparation for the meeting, they asked the jurisdictions how they were using their data, and some very good strategies emerged. CDC should, therefore, unify how health departments use the data.

❖   Bob Moran said that the data collected from surveys of community-based organizations will help CDC project officers work with the CBO's to discover whether the populations that need to be reached are being reached, or whether populations that are just there and are easy to reach are being accessed.

❖   David Napp pointed out that the two breakout sessions would address the use of data.

❖   Kristy Benton of Arizona asked about the evaluation capacity of health departments. The Guidance had led her state to focus on increasing their evaluation capacity. In increasing their capacity, and in receiving further updates on CDC requirements, they had difficulty when they were called on for technical assistance, as they did so without compensation. She also inquired about capacity-building assistance to respond to new CBO Guidance Guidelines. Supplemental money received represents a percent of their budget for evaluation, she said, and they are strained.

❖   Marlene Glassman commented on the pending CBO Guidance, noting that it will consist of two major chapters (e.g., Implementation Planning and Process Monitoring). The structure is the same as the Health Department Guidance, so she did not anticipate that there would be problems with the health departments understanding the Guidance. Moreover, CDC plans for regional trainings for CBO's.

❖   Charles Collins recognized that the over-350 directly-funded organizations would have a number of questions when they received their Evaluation Guidance. CDC is beginning to plan for these needs, putting together a team to help with the CBO Evaluation Guidance. They have four capacity-building providers, and they are working to build their capacity to assist CBO's.

❖   Marlene Glassman was asked to reflect on the basic question that the Evaluation Guidance is trying to answer. There do not appear to be any measures to identify the risk levels of the people who interventions reach. For instance, more "risky" people may be included in a late-night, group-level intervention. It is not clear in the evaluation project whether there are indicators in prevention case management.

❖   Marlene Glassman noted that the Resource Manual will address risk assessments and include sample forms to identify levels of risk. It is up to the health departments to work with grantees to ensure that they are reaching people at high risk to use resources more effectively. Charles Collins agreed, encouraging work with CBO providers to see what form of risk assessment is being done with clients, particularly with the target populations of group-level interventions. The CDC planning representative noted that many applicants assume that just because a population is sexually active, they are at risk, which is not necessarily the case. Such aspects as whether the clients are a sexually active population in a population with a high rate of sexually-transmitted diseases must be considered, he said.

❖   A question was posed about CDC's growing emphasis on prevention interventions, and whether they anticipated collecting data on these interventions in the future, and what they are doing to disseminate information to people who are infected.

❖ The CDC planning representative said that when they review applications for continued funding, they do not see many interventions that include dissemination to infected persons. They have an upcoming conference that will address the issue of interventions with people who are infected, and he expected much more emphasis on it in the future.

❖ Marlene Glassman added that the Guidance did not include data on risk behavior because it is not behaviorally-based. She encouraged community-planning groups to make HIV-positives a priority population and to do appropriate interventions for them. She encouraged the attendees to inform CDC about their work in this population. There is a new table that asks about groups' allocations for interventions for HIV-positive persons.

❖ A participant noted that a number of health departments and CBOs participated over a several-month period in the development of a "how-to" manual for the CBO Guidance. During that period, some valuable bits of information related to the implementation of the Guidance emerged. This information included areas of consideration for revisions in the future. With that in mind, an inquiry was posed as to how that information will be made available to CBOs and health departments. With regard to new standards, an inquiry was posed as to how many jurisdictions have developed and implemented very good standards for their programs (which should be taken into consideration).

❖ The CDC planning representative noted that there would be a session on the CBO Guidance that day, and that drafts of the "how-to" Manual would be available. He assumed that once the draft is approved and revised, then they would be made available to health departments who are working closely with CBO's that are funded by health departments and/or CDC. Suggestions for revising the Health Department Guidance will be taken systematically, along with notes from the meeting, will be taken as recommendations and examined.

❖ Marlene Glassman commented that a project was examining intervention quality standards that could lead to those issues, and to sharing information with health departments and CBOs.

❖ A participant noted that with regard to the local health departments' electronic reporting systems, their department had developed its own system that will be online in six to nine months. An inquiry was posed as to whether they should use their system, or wait for the CDC ERAS system. This participant indicated that he was puzzled by the timing of the rollout of the ERAS system. Many local health departments have invested resources in their own electronic systems and are not sure how best to report the data, whether their systems will be compatible with ERAS, whether the ERAS will one day become mandatory, et cetera. He expressed concern that many of the local health departments are in a "holding pattern."

❖   Marlene Glassman agreed, acknowledging that not developing software for health departments earlier was a mistake. The software would be developed in collaboration with health departments to ensure that it would fulfill their needs as well as requirements of the Evaluation Guidance. ERAS is a different approach and can accept data from a variety of sources.

At the close of this session, the participants reconvened in the following concurrent sessions:

Concurrent Session One:

❑   Outcome Evaluating/Outcome Monitoring
❑   Data Collection, Reporting, and Quality Assurance
❑   Building Infrastructure for Evaluation
❑   Use of Data/Fostering Buy-in

Concurrent Session Two:

❑   Outcome Evaluation/Outcome Monitoring
❑   Data Management
❑   CBO Evaluation Guidance
❑   Use of Data/Fostering Buy-In

Closing Plenary Session

The participants reconvened for a Closing Plenary Session moderated by Aisha Gilliam of CDC.
The following presentations were delivered:

❑   Francisco Sy, CDC
        CBO Evaluation Guidance and the "How To" Manual

❑   Carl Hill, CDC and David Napp, Practical Applications for Public Health
        HD EG Peer Resource Manual

❑   Michael Hughes, CDC
        Future Directions for the Evaluation Guidance

Following the acknowledgments by Romel Lacson, CDC, Aisha Gilliam delivered the closing remarks and officially adjourned the meeting.

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Concurrent Sessions

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Translation Issues/Taxonomy Populations

Facilitators: Nikki Economou, Kira Sloop
CDC Representatives: Kata Chillag, Kelly Bartholow, Tippavan Nagachinta
Health Department Peer: Marquietta Alston, VA
CBO Peer: Rev. Tommie Watkins

These sessions focused on the Guidance taxonomy and how jurisdictions can use it with local populations. Questions addressed included whether or not a jurisdiction can use non-risk-behavior defined populations that are not in CDC's taxonomy, and if so, how this can be done. What are some ways of translating local population to CDC's taxonomy when reporting data? It has been argued that some target populations have been excluded. What can be done to make sure that populations are not overlooked? How does CDC's taxonomy minimize (or aggrandize) the burden on contractors?

The topic was the same for both Sessions. While the presenters delivered virtually the same information, the dynamics of each group were somewhat different. Therefore, more information has been provided in the presenter's summary portion of the document for Session One, while Session Two includes only an introductory paragraph regarding these presentations. The discussion is documented separately.

Concurrent Session One – Translation Issues/Taxonomy Populations

Kira Sloop Facilitator
ORC Macro

Ms. Sloop called the session to order. She explained the purpose and the format of the session, and then introduced the panel members who delivered overview presentations, and/or engaged in deliberations with the participants.

Kelly Bartholow
CDC/PERB
CDC Representative

Kelly Bartholow presented the categories of populations that interventions are designed to address:

❏   Men who have Sex with Men (MSM) covers both men who report sexual contact with men and men who report sexual contact with both men and women.

❏   MSM-IDU is the MSM population that also reports injection drug use.

❏   Injection Drug Use (IDU) are people who are at risk for HIV infection through the use of equipment used to inject drugs.

❏   Heterosexual covers people who have had heterosexual contact with people at increased risk for HIV infection.

❏   Mothers With or At Risk for HIV targets women who are pregnant and either at risk of being HIV-infected or who are HIV-infected and risk transferring HIV to the infant.

❏   General population interventions are not particularly directed toward people at risk, but to the population as a whole.

Tippavan Nagachinta
CDC/CBB
CDC Representative

Tippavan Nagachinta, of the Science Application Team, spoke to the group about available technical assistance (TA) for them. She indicated that technical assistance comes from three sources:

❏   NASTAD, which offers peer-to-peer technical assistance for health departments;
❏   MACRO, which provides TA to states in the area of evaluation; and
❏   CDC, which offers TA to states via the Science Application Team and the Program
     Evaluation and Research Branch.

To access technical assistance, she said it is recommended that health departments contact their
Project Officer, who sends requests to the appropriate TA provider according to the request. The
types of available technical assistance are:

❏   Interpretation of the Health Department Evaluation Guidance;
❏   Clarification of terms and CDC expectations;
❏   How to ascertain the scientific basis of prevention programs;
❏   Process monitoring and process evaluation;
❏   Outcome monitoring and evaluation;
❏   Data collection and management procedures; and
❏   Strategies to improve quality assurance.

There are some limitations to technical assistance, which include:

❏   Data management software;
❏   CDC cannot do evaluations or analyze data for health departments;
❏   CDC cannot come to states and conduct basic training on the Evaluation Guidance to
     CBOs and contractors; however, CDC can offer nationally-distributed trainings on
     evaluation to increase health department evaluation capacity;
❏   CDC can only provide TA and cannot do the work.

She reinforced that health departments should seek assistance via their Project Officers.

Reverend Tommie Watkins
CBO Peer
Greater Bethel AME Church

Reverend Tommie Watkins, from the Greater Bethel AME Church in Miami, Florida, is the
Program Director of an HIV Prevention Education Program that works with the health
department. He explained that their faith-based initiative began about six years ago.   In
communities of people of color, the church is the most powerful entity; therefore, they moved
toward a program that is progressive and that addresses the needs of their community.   They
accomplish this goal through the HIV Partnership Prevention Plan. In Miami/Dade County, the
main target population is Black MSMs and their partners, and the second target group is Black
women, which includes Creole, Haitian, and African-American groups.

They reach their populations through prevention education, going to schools and other churches,

where they make condoms available. They also conduct a two-hour weekly group-level intervention that helps their populations empower themselves. The curriculum lasts for twelve weeks, and its goal is to encourage men to talk about all issues that they encounter, including their sexuality. A women's group meets twice a month called "Self Help and Empowerment Group," or "The SHE Hour." In addition, they have a street and community outreach intervention, wherein they conduct risk and needs assessments in the field and invite members of the target population into their Prevention Case Management component. They link their clients with other case management agencies, but they mainly focus on prevention case management.

Reverend Watkins encouraged the group to consider faith-based initiatives and to look at progressive churches as sources for help. His program has found that in the faith community, there are many pastors who want to address HIV, but they do not want to talk about sex and sexuality. Two Sundays a month, they have a program called "The Ministry of Reconciliation," where the church opens its doors to people who have HIV and who identify as having different sexual orientations. It is a non-threatening, inclusive, and affirming environment from an African-American perspective in a traditional denomination. It helps people heal who have been marginalized from the Black church. They use the book *Black Church and Sexuality* by Dr. Kelly Brown Douglas, which includes a twelve-week curriculum, and then follow the book study with a traditional worship service. They also use *The Good Book*, by Reverend Peter J. Gomes, an African-American Baptist who identifies himself as a homosexual. His book takes the Bible from an historical, critical perspective, because traditionally, barriers to faith-based initiatives have included the interpretation of Scripture.

In conclusion, Reverend Watkins said that they collaborate with the health department and other CBOs to try to meet the needs of the people.

Discussion Summary:

❖   An audience member asked Reverend Watkins to what extent they were able to engage MSMs who do not identify themselves as gay; and if so, how they are able to do so.

❖   Reverend Watkins responded that Miami is unique in that its population is segmented due to its cultural and ethnic differences. The Black gay community is nearly invisible in the county. Many people commute to Ft. Lauderdale and to other cities that have a more inclusive environment. Their approach is to go to straight bars and to distribute their empowerment and support group information. When people see a church that is open and affirming about sex and sexuality, they often open a dialogue about being tested and other issues. The church also has a media campaign, which has resulted in people contacting the church for services. They have also addressed the barrier of traditional, Biblical rhetoric to MSMs by moving to publish a pamphlet that addresses those Scriptures that many people say are damning to MSMs or WSWs. This pamphlet will give perspective on what the Bible really *says* and what the Bible really *means*. Their

initiative is to include this pamphlet in a packet with a condom and their empowerment information. People may not adopt their theology. He stressed that they are not out to convert people. All they want is to educate people, which is why their interventions are aimed at prevention education.

Marquietta Alston
Health Department Peer
Virginia Health Department

Marquietta Alston spoke about how their department included the CDC-identified risk behavior populations with the state's taxonomy. Before the Guidance, Virginia collected mostly process and monitoring data. This data included gender, types of sessions, and evaluation. The contractors were required to apply some of their budget to evaluation, reinforcing the importance of evaluation. With this preparation, the Guidance was not foreign to them. The Guidance still raised many questions concerning the populations about which they would be collecting information. A formula was already in place for prioritizing populations, which included factors such as:

❑ Risk
❑ Need
❑ HIV/AIDS statistics for specific populations, which were then compared to the general population
❑ Funding directed to certain populations
❑ Information gathered from town meetings
❑ Other factors

At the outset, the contractors wanted to keep their initial populations. After the initial resistance, though, they were able to work together to make the two languages mesh.

After looking at CDC's definitions and comparing them to Virginia's definitions, they found commonalities and used CDC's definitions to define their priority populations. Finally, they were able to combine the languages. The categories included:

❑ Racial/ethnic minorities
❑ MSMs
❑ Women
❑ Youth
❑ PWAs
❑ Homeless
❑ Sex workers
❑ Mentally dysfunctional inmates
❑ General population

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Marquietta Alston pointed out that homeless, sex workers, and mentally dysfunctional inmates represent "special populations" It is difficult to gather statistics on these populations, but there are reasons that they are at-risk, so Virginia still wanted to include them in their taxonomy.

Contractors identify their intervention's target population, the intervention that they are using, and then they check each of the categories that applies to their population. They also have to specify the risk behavior that they are trying to address. The health department requires quarterly reports on which contractors can indicate the total number of people served, their progress toward their goals, and the numbers of people that they have reached in each category. This method incorporates quality control into the contractors' system and allows them to make changes in their programs if they find that they are not reaching whom they wanted or expected to reach.

She stressed that combining the language does not eliminate all problems. For instance, the homeless population's risk levels and characteristics are difficult to predict, so the health department asks its contractors to do their best when making their projections. Many of them use past experience for those estimations. The same problems surface with the incarcerated population. Sometimes contractors can guess what risk behaviors they will find, and then can address those interventions.

Marquietta Alston said she doubts that in the future they will ever use just the CDC terms. Her understanding of the Guidance is that it was not meant to replace or minimize efforts that are already in place. CDC merely needs a common language to make national reports of what is being addressed in HIV programs. In the prioritization process, the categories may change slightly; for instance, the group "women" may be combined with the "heterosexual" category. There is no one answer to the problem, she concluded, but the combination of languages has made collection easier for their contractors, and they are still able to aggregate the data for CDC while satisfying needs at the local level.

Discussion Summary:

❖   A member of the audience asked Marquietta Alston to describe the difference between basic street outreach, intensive street outreach, facilitated street outreach, and collaborative street outreach.

❖   Marquietta Alston replied that *Basic street outreach* was a means to go into the community to distribute information with little engagement – it is not an intervention, but a strategy. *Intensive street outreach* incorporates more contacts and more lengthy encounters and may have an informal risk assessment component. It may also include a referral. *Facilitated street outreach*, which follows the other two, involves making an appointment for one-on-one with a person. *Collaborative street outreach* includes more

stringent follow-up, which may push the envelope of case management. Essentially, the different types of outreach represent different levels of contact. She added that collaborative and facilitated outreach may include a transportation component.

❖ Another audience member observed that the progression seems to be from outreach into individual-level intervention. Collaborative outreach also includes work with other agencies.

❖ Mary Parsons, also from the Virginia Department of Health, further clarified the procedure for making appointments with people encountered during these interventions, pointing out that there are multiple contacts with clients, which lead to the more formalized "appointments."

❖ Another participant remarked that the idea of specificity in target populations at the local level is a good idea. The focus is trying to translate those categories into transmission risk.

❖ With that in mind, an inquiry was posed as to whether her group had developed a profile sheet for contractors to complete at every encounter.

❖ Marquietta. Alston replied that the health department had not stipulated the use of a certain collection tool. They have provided samples of tools to contractors and samples of risk assessment tools, but have left the collection methods up to them.

❖ A question was posed as to whether, when they collect data from contractors, it is in aggregate form or at the individual level.

❖ Marquietta Alston replied that the contractors collect their data by population and by intervention. The health department then aggregates the data.

❖ Another audience member asked about working with trans-genders.

❖ Marquietta Alston said that they have addressed the topic, and have encouraged their contractors to focus on a particular risk behavior rather than trying to classify the person at risk. Work in that population is minimal in her state.

❖ An inquiry was posed by a participant, whose CPG has prioritized four categories of youth, as to how Virginia classifies youth.

❖ Marquietta Alston replied that in some interventions, there might not be direct questioning of risk behaviors. The question regards what behaviors are being addresses. In Virginia, the focus is on heterosexual and young MSM groups. Rarely do contractors

put down IDU. She said that while much of the work is estimated, they try to get self-reported risk assessments.

Kira Sloop then had the participants in this session break into smaller groups. She pointed out that there are great examples from a variety of sources. Virginia's strategy of combining languages is but one option. Other local departments are opting to use only their own terms, and then the state health department translates the data at that level to send to CDC. A third strategy is adopting the CDC taxonomy uniformly and requiring contractors to do the same. Any of these strategies might apply to a given jurisdiction. She requested that they discuss their options in their small groups, and then assign someone to report out to the larger group. The report from these breakout sessions included the following feedback:

Table #1:

❑ Washington state totally uses CDC's risk behavior population, having decided after much discussion that it would be easiest to collect information the way it would have to be reported to CDC.
❑ Vermont is also using CDC's risk behavior population taxonomy.
❑ Virginia uses a combination of methods, as discussed in the presentation.

Table #2:

❑ Pennsylvania has thirteen different population categories, and Iowa has seventeen different population categories. Some programs are doing the translation for the grantees, while others are asking the CPG to use the CDC category to prioritize their populations, moving toward using CDC categories.
❑ One strategy for collecting data is used in Maryland, where all interventions except for outreach use some kind of risk assessment tool that is self-administered and turned into the health department.
❑ In Alaska, the approach is to go by the intended population of the intervention.

Table #3:

❑ New York City uses the third strategy, which is having contractors use both CDC and their own local terms, which is similar to Virginia's approach, but more detailed.
❑ Utah's contractors use the CDC taxonomy exclusively, and they have a system whereby contractors and sub-contractors can use a website to send their aggregated data directly to the health department.
❑ Major challenges include getting the local level to come to a uniform language. It was the consensus that the health department is the translator of the information to CDC.

Table #4:

❏   All states at this table (Florida, Georgia, New York State, and the Federated States of Micronesia) use a combination of local and CDC taxonomies. Once the CBOs report in local terms, the health department translates that information for CDC purposes.

❏   Challenges arise in risk behaviors and in comparing them to populations.

❏   Target populations such as youth and women that are not addressed by the CDC terminology are captured in the local taxonomies.

Discussion Summary:

❖   A representative from Alaska noted that according to the CDC Guidance, HIV-positive persons are not being captured, despite national attention being directed toward interventions in that population.   In her state, they completed an RFP process to fund grantees to do interventions for HIV-positive persons. They can collect data according to the risk factors of that population, which satisfies grant oversight at the local level, but in reporting those interventions to CDC, they will be classified by risk populations. The current Evaluation Guidance Data System will not be able to provide CDC at the national level with information about what interventions and what resources are aimed at HIV-positive persons.

❖   A CDC representative said they appreciated the comment, adding that distinguishing between transmission categories and other data sets is an issue to be addressed. It could represent an additional data element without changing the data set entirely.

❖   Another participant raised the issue of how to place non-identified MSMs in the plan. Is it general population work, community-level intervention, or is it reaching MSMs? Her thought was to follow the intent of the intervention. Her group also discussed the risk categories for substance use and how to address the risk that comes from use of other substances and other contributing factors. They concluded that there is no way to capture when the substance use brings the highest risk.

❖   Reverend Watkins noted that his table had touched on the same issue, which includes topics of cultural sensitivity. With their next round of RFPs, he said they have chosen to address men, women, and youth "to include men who have sex with men and women who have sex with women." They are trying to remove stigma from the group and to be more inclusive. Their work with the prison population has yielded more open identification of risk. He stressed that they must remember that the <u>risk</u> is men having sex with men, but the <u>population</u> is Black men.

❖ A participant from New York City remarked that the new reporting tables do not include a method to determine the number of non-Hispanic Whites. It is not clear how the CDC manages that. There are black Hispanics, et cetera, and a cross-tab is not possible in that category. Traditionally, he said that when Hispanic is a co-equal category with other races, it is possible to break out non-Hispanic White, non-Hispanic Blacks, et cetera. Estimates are possible, but not concrete numbers. Another group member described a recent study in which they found that many Latinos did not check any race on their forms. After consulting with CBO's, they discovered that Latinos do not know how to identify with a "race" as they have never been defined in such a way. A similar confusion, which may come from not educating the community, occurs with Native Americans.

❖ A participant from Washington, D.C. commented that the age groups are too broad at both the young and the elderly ends of the spectrum.

❖ Kata Chillag responded that CDC realizes that there are limitations to the categories, which are often created by the Office of Management and Budget. They want to know the nuances of local situations, but they also want a very basic way to communicate, using similar categories. They hope that future activities will give them opportunities for cross-tabs. They encourage local, user-defined categories which can be included in the narrative sections of the reports.

❖ Nikki Economou asked the audience to share their challenges and experiences, including how CDC can help them go from where they are to where they need to be. A group member commented that conferences and session such as this one are very beneficial and that they would appreciate more workgroups with specific agendas that could generate recommendations for future changes and work. Then, work at the local level can have an impact on the national Guidance and its revisions.

❖ A participant noted that consistent communication is the best way that CDC can help the health departments. Even a website with questions and answers that are accessible to everyone can help with TA. This site could also act as a clearing house for questions and comments and a listserv. CDC may not have all the answers. Other jurisdictions may have answers from their experiences and successes. Nikki Economou agreed that good answers come from the field.

❖ It was noted by a participant that materials or TA for the Latino population that could then be translated to the CBOs to collect data, would help alleviate the problems that they have with collecting information in their population. He also asked about the development of software for CBOs to be able to collect their own data.

❖   A CDC representative answered that software for directly-funded CBOs was being developed, which would complement the upcoming health department software.

❖   An attendee from Georgia commented that CDC had worked with them to modify ERAS to be included at the local level, and they would pilot that project in January.

❖   Nikki Economou added that health departments want and need information from directly-funded CBOs so that they can fill in any gaps, and so they can share information.

❖   Gary Uhl described a study that would involve going to six health departments and asking them what they need to conduct program evaluation better. He said that they would try to reach states that had a greater need.

❖   Nikki Economou said that they plan to share that information with the Division at CDC to help with capacity-building and other resources. Low-incidence states do not get enough attention.

In conclusion, audience members agreed that health departments need the following from CDC:

❑   Financial resources to set up evaluation systems
❑   Clear guidance
❑   Consistency so that they can catch up

Concurrent Session Two – Translation Issues/Taxonomy Populations

Kira Sloop
Kata Chillag
Tippavan Nagachinta
Reverend Tommie Watkins
Marquietta Alston

As in the earlier session, which was the identical topic to this, Kira Sloop called the session to order. She explained the purpose and the format of the session, and then introduced the panel members who delivered overview presentations, and/or engaged in deliberations with the participants. Kata Chillag, CDC Representative, reviewed the categories of populations that interventions are designed to address. Tippavan Nagachinta then briefly spoke to the group about the technical assistance (TA) that is available to them. She reviewed the same information she did in the earlier session. As he did in the morning session, the Reverend Tommie Watkins addressed the group about his faith-based HIV prevention education program in Miami, Florida. Marquietta Alston addressed the group regarding the Virginia Health Department.

Discussion Summary:

Following the Presentations of Kira Sloop, Kata Chillag, and Tippavan Nagachinta

❖ A participant asked about the length of time between submitting a request and actually receiving the TA.

❖ Tippanvan Nagachinta replied that the time frame varies according to the request, and that more details would be covered in the morning session. She said that they hoped to be able to provide health departments with an idea of the turnaround time to help them in their planning. Nikki Economou added that in some cases, the response can come as fast as in 48 hours.

Following Reverend Watkins' Presentation

❖ A participant inquired as to how the two books Reverend Watkins described are used.

❖ Reverend Watkins replied that the first hour of the service is a book study, while the second hour is a traditional church service. The books are special because often in the Black church, people with HIV or with different sexual orientations are stigmatized or marginalized. They give the books as gifts to local faith-based leaders for them to use. They help the clergy address these people and help the church to be more inclusive, he said. He feels that the old approach from the church is one of the reasons that HIV has such a high incidence in the black community.

Following Marquietta Alston's Presentation

❖ An inquiry was posed as to why MSMs were included in both "population" and "risk" categories.

❖ Marquietta Alston replied that when CPG did their prioritization, MSM was identified as a target population in and of itself, and it happened that CDC includes that category as a risk behavior. The form, then, has space for both. If MSM is marked as a population and not a risk behavior, then the state will ask the contractor why.

❖ Another audience member noted that his state collects information the same way as Virginia, and he encounters problems when asked to sort out, for instance, how many Black, MSM, IDUs are reached by a given intervention.

❖ Marquietta Alston said that Virginia has not sorted out that problem either, but that there is a way that contractors can indicate that they are working with, for instance, PWAs, so they can partially answer the question.

❖ A CDC representative asked about trans-genders, which are not included as a population group. He also inquired whether the definition of "youth" was according to CDC guidelines, or if the state used another definition.

❖ Marquietta Alston responded that the trans-gender issue had come up, and so the state encourages their contractors to focus on what risk behavior they are trying to reach. Also, there is not much work being done in the trans-gender population. The CPG is talking about the issue, she said, so some changes are possible. She said that they use the CDC's definition for "youth." One of their problems is working with inconsistencies in age ranges and definitions.

❖ A participant asked how long it takes to complete the forms.

❖ Marquietta Alston replied that she did not know how long it takes to fill out the intervention sheets, although she said she has heard no complaints that it takes too long to complete them, probably because the contractors have been involved in the process all along.

❖ It was noted that standardization is difficult when age ranges are different. For instance, "youth" is defined as under 24, but the age ranges are "below 19," and "20 - 24." In academic settings, "outcome" and "impact" evaluations are the exact opposite of what CDC uses. There have been conflicts between the language that CBOs use, then, and the language that some evaluators use.

❖ Kira Sloop acknowledged that that had been a debate for decades. No changes are expected becase people in the evaluation field cannot even agree on the issue.

Kira Sloop then divided the session into smaller discussion groups. She reminded them that David Napp had identified three strategies for translating local populations into CDC's data collection system:

❏ A combination of CDC terms and local terms;
❏ Contractors' complete adoption of CDC taxonomies; and
❏ Contractors use their own, local terms, and the health department translates the data to send to CDC.

As with the earlier session, she asked the small groups to reflect on their systems, their challenges and how they have overcome them, whether there are target populations that are not being addressed by the CDC categories and how they have coped with that, and how CDC can help them with the translations. This group did not report out as did the first group. Instead, they engaged in an open discussion period.

__Discussion Summary:__

❖   A participant inquired as to how Virginia went about allowing their contractors to use their own categories. He described how his CPG had divided his state's population into target populations and then designated interventions for each of them. Each client would have fit into several of those categories which made it very confusing. When interventions are targeted to a neighborhood, they had to guess what populations lived there. He also wondered how many contractors would say that they had an insufficient delivery plan for one of their activities

❖   Marquietta Alston replied that at the state level, they did not do service delivery for contractors. Their work plans were created in-house, and then state staff would evaluate them so that their categories were acceptable. They encourage their contractors to incorporate behavior theories into their plans, and they also had in-person training sessions.

❖   A participant from Georgia described her state's training, which combines in-person sessions with follow-up session. Most of their agencies have fairly straightforward target populations, she said, but some agencies have had trouble with the new terms – in particular, an agency that has group-level, individual, and outreach services to migrant farm workers. These people are not allowed out of their camps, so the interventions are hit-and-miss. The contractor found that group interventions with the commercial sex workers who work with the migrant farm workers were a good way to access that population. Another agency that used media such as billboards had trouble linking their efforts to the new terms as well, but the state was able to work with them to refine their campaigns. They have quarterly meetings.

❖   A participant from Oregon, where they initiated a new priority-setting process, said that they decided to adopt the CDC taxonomy and then use sub-populations to better define the populations. For example, MSM was their top population in both urban and rural areas. The first sub-population was MSM of color, followed by young MSM. They tried to capture all of the populations that they had accessed in the past and apply them to the CDC categories. He believed that there should be an HIV-positive category, as interventions are very different for that population. With the CDC's push toward serving persons with HIV, it made sense to add that category.

❖   Linda Kay of the Behavioral Intervention Research Branch works on the Prevention Research Synthesis Project, and they are collecting information on all HIV interventions since 1988, trying to synthesize and categorize the interventions. They have run into the same problem trying to get enough information about interventions. She asked if there was any thought going toward including six behavior categories to capture risk, but to add other, important population characteristics. For instance, the "heterosexual" category

is not enough for youth, which gets such different interventions.

❖   Nikki Economou commented that those points were consistent with other comments. They have to look at the behavioral and then look at contributing factors, which would include HIV status, homelessness, incarceration, prostitution, and drug use that is not injection drug use. All of these factors contribute to behavior. To capture that information, she said they would all have to use their own categories. To work from a national perspective, though, there has to be consistency.

❖   Another participant commented that the issue of trans-genders has been one with which they have struggled. Their CPG has trans-gender representation, and those representatives do not want to be categorized as MSMs. They are thinking of sub-categories, because there are categories even within trans-genders. The relationship between the African-American community and MSMs is very strained. They are adding HIV status as a category overall and reinforcing with their facilitators to gather that information along with basic demographics, anonymously. This information will also help guide future services.

❖   In speaking with a group of trans-genders, another participant said they discovered great variety within that group. Some of them went from being men to being women who are having sex with women. The issue has come up in New Mexico, commented another attendee. She asked her trans-gender co-chair of her CPG about his feelings, and he related to her that the risk issues were not only about *with whom* people were having sex, but also having to do with the "affinity grouping" and the increased isolation that he felt within the MSM social network. There is a sense of shame within the more "macho" MSM community which points out that risk behavior is defined by a number of issues.

❖   Another speaker told the group that his CPG advocated making MSM and gay men two separate categories. The idea behind the split is that there are many MSMs who do not identify as gay men, and there are gay men who have a culture and a community. They are two very different things. MSM was left as the primary category, but they did keep gay men as a separate group to target because of the differences in how the two groups should be targeted.

❖   Kata Chillag commented on the CDC perspective, reminding the group that CDC sought a basic set of risk-behavior-based categories. This is not the whole compendium of CDC's interests, she assured them. They know that there are limitations to the categories, and they struggle with them, too, but they really want a common language for the country. She said they also wanted to hear about other activities in the narrative portions of the data collection forms.

❖ Nikki Economou pointed out that, for instance, a gay man who is Latino may identify himself first as a gay man, then as a Latino, or vice-versa. The intervention will depend on how an individual perceives him- or herself. The interventions are related to the populations.

❖ Another participant said he appreciated CDC's dilemma given that at the state level, he feels mistrust from people at the local level. It does translate when they miss populations, though, and people feel that CDC is not collecting information on a given population. If the data is not collected, then people are not going to own the responsibility for the epidemic. He realized that it was difficult, but stressed that the message has to get from CDC to the community that their HIV concerns are being addressed.

❖ Kata Chillag said she understood local situations, and added that any national instrument will miss data points, which may have real consequences for the interventions that are being designed and how agencies deal with their communities.

❖ Ms. Kay mentioned her project's difficulty in linking the mode of transmission to the intervention. She realized that they had already made changes to the Guidance, and knowing that, she expressed her hope that CDC would consider keeping the mode of transmission, but adding another component for the populations. There could be consistency with this method.

❖ Kelly Bartholow indicated that this process has gone on in consultation with local health departments. The Guidance is intended to consolidate the categories, not to eliminate variables that are useful at the local level. CDC needs the categories for its minimum core data set, but that does not mean that a helpful local process should be ignored or replaced completely. In the next funding cycle, she said comments like these would probably be incorporated. The Guidance will be revised. She reminded them that they are trying to capture contextual issues in the narrative, so health departments and CBOs can provide the bigger picture of their work to augment the data points.

❖ Nikki Economou asked what CDC could do to help them make these translations.

❖ A participant from New Mexico commented that the issues of how risk groups are described, defined, and prioritized are not just about the epidemic, but also are about deciding where money goes. For that reason, the taxonomy becomes even more important, especially at the CPG level. Because of this impression that the funding channels are related to the taxonomy, the trans-gender issue is a contentious one at the community level, she said.

❖ Kelly Bartholow recognized that point, because health departments have to report how their funds are tied to the surveillance data. There is a mechanism to address that gap, if it exists, but it is a legitimate concern.

❖ Nikki Economou pointed out that community planning is included in the process to help them direct monies more efficiently and effectively, according to the needs of the individual area. The epidemiology alone is not enough, she said.

❖ A participant said that he could live with translating up to the CDC categories if there were an official way to capture the other information. He expressed hope that people would be able to get at the data so that they know that populations are not being missed.

❖ A participant from Idaho expressed concern about the evaluation tools not from the contractor level, but the feedback from the field was in the area of people who are expected to identify those who attend interventions who may not show up on epidemiological data. In a rural area, with a limited number of people and limited number of meeting places for the gay community, the facilitator can identify respondents quickly, even if the information is confidential. More broad categories are better for her situation, as self-identifying into even smaller categories will make things even more difficult for the people who conduct interventions and outreach. Anonymity is impossible in a community like that one, she said.

❖ Another participant told the group that he stresses with his contractors to think of the intervention first. They should be able to collect the data that they can reasonably collect without interfering with their intervention goals. A multiple-session workshop will yield a more detailed picture than an outreach activity, he said. Broad categories may be easier, but they do not give a full picture of the work that is being done. Perhaps there is a way to highlight special programs and disperse information about more specific populations.

❖ The representative from Georgia said that her epidemiologist meets with the CPG. Based on those requests, he highlights special populations within the epi profile. This way, the data is captured. They only recently made Asian/Pacific Islander a separate category.

❖ A participant suggested that the way that CDC could help the departments of health is to give their data back to them in a useful format. Some health departments will conduct outcome evaluation to show the effectiveness of their interventions. More detail would make those reports more useful. The different branches are working together more efficiently at CDC, so they are able to make each others' jobs better.

❖ Marquietta Alston inquired about outcome evaluation and what they could do. They are

not supposed to do quasi-experimental projects.

❖   Kelly Bartholow replied that they are in negotiations with IRBs about what projects are appropriate. They should not use prevention money to conduct research.

At this point, a number of members in the group requested that the remainder of the IRB discussion be allowed to take place off the record. Therefore, the rapporteur turned off the recording equipment and ceased making notes via laptop computer.

Data Collection, Reporting, and Quality Assurance

Facilitators:	Tim Quinn, Tom Creger
CDC Representatives:	Choi Wan, Xiahong Mao-Davis, Cynthia Prather, Mari Brown, Winifred King
Health Department Peer:	Hope Cassidy-Stewart, MD
CBO Peer:	Claudia Montagne

The focus of these sessions was on the data collection and reporting needs of jurisdictions, and related quality assurance issues. Discussions focused on questions such as: Is there help for jurisdictions to identify their quality assurance TA needs? Is TA available to ensure the system can meet CDC, state, and local data collection and categorization needs? How can jurisdictions ensure the transfer of technology to the sub-grantee and subcontractor level?

Concurrent Session One – Data Collection, Reporting, and Quality Assurance

Tim Quinn
Facilitator
CDC/PPB

Tim Quinn called the session to order. He explained the purpose and the format of the session, and then introduced the panel members who delivered overview presentations, and/or engaged in deliberations with the participants.

Choi Wan
CDC/PERB
CDC Representative

Choi Wan gave a background presentation on data collection, quality assurance, and data reporting. He explained that evaluation data is divided into three major types:

❏   Quality of interventions being provided by CDC Heath Department grantees
❏   Characteristics of clients targeted and reached by interventions
❏   Effects of interventions on client behavior and HIV transmission

There is a conceptual framework for the Evaluation Guidance, and different components of the framework correspond to different evaluation activities. Some of the components are not required, for instance, for this funding mechanism, outcome monitoring is not required. Each evaluation activity requires a different data collection process, and therefore a different strategy, even within a single jurisdiction.

CDC envisions the ERAS system acting as the reporting system for health departments. He expressed his hope that the system would reduce and ease their paperwork load as well as improve the quality of their reporting. The ERAS system will be available for health departments to use free of charge.

He said that another way to look at evaluation processes is to examine the data flow from the client level to the interventions to the provider to the health department to the CDC. In thinking about data collection procedures, Choi Wan urged the group to think about quality assurance procedures at each step in the data flow. Quality assurance (QA) includes accuracy as well as quality of the reported data. This point is important in understanding the effectiveness of HIV prevention efforts conducted by jurisdictions. Quality assurance has to be an ongoing activity with data reporting sources. The ERAS provides validation, but quality assurance goes beyond the ERAS system, as each part of the data flow must incorporate quality assurance measures. He noted that training staff at all levels will help to ensure quality.

Winifred King
CDC/CBB
CDC Representative

Winifred King, of the Science and Application Team, described available technical assistance (TA) resources as being:

❏   NASTAD, which offers peer-to-peer technical assistance for health departments;

❏   MACRO, which can provide TA to the states; and

❏   CDC, which offers TA to the states via the Science Application Team and the Program Evaluation and Research Branch.

If TA is needed, Winifred King pointed out that the first step is to call the Project Officer, who will contact the Science Application Team to handle the request. Types of available TA include:

❏   Interpretation of the Health Department Evaluation Guidance
❏   Ways to ascertain the scientific basis of prevention programs
❏   Process monitoring and process evaluation
❏   Outcome monitoring and outcome evaluation
❏   Data collection and management procedures
❏   Strategies to improve quality assurance

Available TA is not limited to that list, she assured the group. There are, however, limitations to how CDC can assist health departments. These limitations are due to limited staff resources and other reasons:

❏   CDC cannot do the evaluation for the health department
❏   CDC cannot analyze data from individual states
❏   CDC cannot come to a state and conduct basic training on the Evaluation Guidance

She indicated that CDC will offer national training sessions on evaluation to health departments and CBO's.

Hope Cassidy-Stewart
State of Maryland Health Department
Maryland's Data Collection, Reporting, and Quality Assurance

Hope Cassidy-Steward indicated that before the Evaluation Guidance, the Maryland Health Department ran monthly and quarterly aggregate data collection for all of their intervention types. Hard copies were mailed to the Department, where they were aggregated and then sent to the CDC. The data was not meaningful, however, because many of the numbers were estimates. July 1, 2000, marked the beginning of the first year of implementing process monitoring in the state of Maryland. This process involved data collection tools tailored by intervention type, intervention forms, participant forms, sign-in sheets, and centralized data entry, analysis, and reporting. Maryland processes all of the data and reports it to its vendors.

Their two goals for their system were:

❏   Valid information
❏   Standardized information

For valid information, she said they wanted client-level data, including age, race, demographics, and risk. Self-reported data was preferable, when possible, to avoid relying on the perceptions of facilitators. They hoped to create an accurate picture of HIV prevention in Maryland. Across the state, data should be collected in the same way so that the health department could compare information from different projects in different settings to create baseline data for evaluations and future comparisons.

Data collection instruments are client-level for all interventions, except for public information that comes from sources such as health fairs. The data includes self-reported demographics and risk information, when possible and appropriate. The health department had hoped for a single data collection tool that could be used all over the state, in every intervention, but they learned early on that different intervention types mean that different levels of specificity and information are feasible.

Hope Cassidy-Stewart said that ILI and GLI, the more intensive, skills-based interventions, use participant forms in English and Spanish. They include self-reported demographics and risk and are confidential. For health communication sessions, they use sign-in sheets, which capture some demographic information. Across their interventions, they use intervention forms to look at content. The facilitator completes the form, which tries to capture the context in which clients are being reached. For outreach activities, there is an outreach form, which is a grid that workers can take into the field and note after their encounters such information as perceived risk, the content of intervention, whether a referral was made, and the distribution of prevention devices or materials. The area of prevention case management, counseling, and testing, has forms and

procedures that they have been using for years, and they are still using them.

A year before implementing the evaluation guidelines, health department staff began to devise how to develop the instruments. Some of their challenges included:

❑   The instruments have to be used across the state, in diverse settings, with diverse intervention types;

❑   Collecting sensitive risk information and the accompanying concerns about confidentiality; and

❑   The dramatic change from the previous data collection system.

After the health department staff created a list of needs for the data collection system, they created drafts of systems and piloted them across the state, in different settings and with different interventions in different target populations. They sought feedback from both the facilitators and the actual participants. Based on this feedback, the revised forms were implemented on July 1st. Six months later, they conducted an assessment that included site visits, interviews, and collection of more feedback. They have just completed the revision of their forms for the second year.

Confidentiality was a big concern among vendors and participants, she said. Participant forms that collect risk information are only used in more intensive interventions. In Maryland, youth under fourteen cannot answer these questions, and some school-based settings prohibit those questions as well. The forms are anonymous and put in sealed envelopes. They conducted statewide training sessions before the first year of implementing the system. The first year was still very difficult. Not all vendors complied with the new system, the data quality was not consistent, and vendors are still not all "on board." They have enforced the importance of completing the forms, though, and they have conducted updated training sessions.

The new data collection systems represent a big change for contractors, and they met with a great deal of resistance. In their state, their vendors have become very interested in the content of the forms. They are very active and vocal in training sessions, which indicates their interest in getting the system right. Their biggest challenge has been to create instruments that work in a variety of settings, that make everyone happy, and that collect the kind of statewide data that they can use. She was heartened by the vendors' engagement in the process.

The health department aggregates the data and then sends it back to the vendors, she said. On a monthly basis, they send a summary to the vendors, internal managers, the state legislature, and CDC. One of their biggest goals for their system is to make the information accessible and to actively contribute to program improvement. They compare the results with the design, working with individual vendors to understand the importance of the information and see its value in their

day-to-day operation.

At this stage of their instrument, quality assurance is the most difficult aspect. In the first year of the system, they understand that the quality of their data is not very high. The information is more accurate every month as more vendors report. One of the reasons they do centralized data entry is to monitor the quality of the data in the first years. Their vendors vary in technical capacities, so the health department can work closely with them. Site visits are a part of their system, as it is important to ensure that the forms are being used appropriately and that they are being used quickly and accurately. In conclusion, she noted that copies of the instruments would be available at the swap meet.

Tim Quinn thanked the presenters, then broke the large group into three smaller groups. Each attendee was asked to write his or her most pressing question about data collection on a 3 x 5 index card. Then, in the smaller groups, they discussed the questions. A listing of each group's notes follows:

Group One Notes

❏   How do you make a data collection form that vendors will understand and use properly?

➡   Involve them in the process

❏   How do you motivate CBOs to collect the data you want? What kind of incentives could be offered?

➡   Funds
➡   Feedback
➡   Highlighting folks

❏   Providers/vendors do not understand: 1) the difference between number of interventions the form covers and number of clients or contacts (these numbers are not the same); 2) how to complete Hispanic/not Hispanic and then do race tablets.

➡   One-on-one TA with CBOs

❏   Garbage in garbage out: quality of local data collection, quality when aggregating data, steps that need to be taken to "raise the bar" or "kick it up a notch."

➡   Start with RFP elements to address QA specific, constant communication demystifying the whole process
➡   Pay attention to how you communicate data back to contractors

❏   How to retain client confidentiality in rural areas with small numbers of clients:

➜   In extremely small cities tell contractors not to collect data that would compromise confidentiality
➜   Consider your system to see who sees data direct submission or through several layers

❏   How do we best do training and provide TA on our new web-based system?

❏   Suggestions for improving: CBO and local HD staff having basic computer/data system skills:

➜   This is difficult often because of turnover/low pay/lack of skills
➜   Look to see if you have a trained pool available
➜   Never train just one person in an agency
➜   Internal state systems have training available, can contracted people sit in on these

❏   Does anyone have experience with unique identification numbers for clients in order to un-duplicate clients served by more than one contractor or the same contractor over time?

➜   HIV and name to code system in Montana
➜   In California, tracking referrals use matching criteria like DOB and gender
➜   Clients don't have problem usually it's the advocate who resists collection of coded information

❏   How do we validate required data to contractors for buy-in?

➜   Timing the question back to the field staff and ask how it can be good for them – why is it used?
➜   Use data for grant-writing purposes
➜   Make it part of RFP process
➜   TA on how to collect data (site visits)

❏   How do we market the evaluation system, especially the forms to get everybody to use them and get information that reflects quantity and quality?

➜   Contractor specifically focused on evaluation. Ready to respond and meet individually with contractors
➜   Contractor very community-friendly could relate to CBO's

➡   Road show around state trying to discuss with CBO's what they do/need
➡   Connect researchers with CBO's through local universities
➡   Do site visits to CBO's

❏   How do we minimize the time spent collecting and reporting data (and receiving data) and still maintain good quality/reliable information?

➡   Clerical staff can enter basic data for aggregate data
➡   Maine reports go through clerical staff, then data manager – demographic/ narrative reports with time-lines, documented written protocol
➡   TA and data management at CBO's can simplify data
➡   Provide CBO's TA on data collection/spreadsheets

❏   What would be the minimum requirements for program monitoring? In small states with small programs, it's difficult to implement elaborate processes due to minimal staff available to carry out the workload.

➡   CDC example of how western states utilized contract to do monitoring
➡   Do the best you can with what you have
➡   Data can be submitted in various ways (i.e. process don't get caught up in format)

❏   Training of agency members for data collection – how to fill out the data forms and getting agencies to do it:

➡   Don't pay subcontractors without forms properly completed – "form doesn't arrive, check doesn't go out"
➡   Web-based training to help

❏   How can we get an accurate number and picture of individuals served during HERR activities? (i.e. usually collect data based on CP6 and CDC needs). If we get questions that deviate from that hard to answer for education, outreach?

➡   Aggregate data can accomplish the evaluation need
➡   Don't necessarily need individual data

Group Two Notes

❏   How do we translate our data into those nifty CDC three-way tables?

❏   How do we develop a simple, not time-consuming, user-friendly, data collection form which captures required data for CDC plus risk behavior?

❏ Sufficient capacity (HD and CBO) to initiate process for data collection/instrument development.

❏ CBO-level understanding of how their existing programs/interventions relate to the evaluation guidance and the impact of confusion on how data is entered. NOTE: we have an extensive electronic system already in place.

❏ Federated state of Micronesia – no data collection (standardized system in place) – lack of resources (instrument, form) database.

❏ We are in our second year of using newly created forms for collecting data on small group sessions. Problem: CBO translation and use of sign-in sheets in a consistent way so that information is translated correctly – sometimes don't use one sheet.

❏ What are the "best practices" being implemented at the provider level – instruments and methods for collecting data?

❏ Must every state "re-invent the wheel?"

❏ What are some strategies for quality assurance in data collection and reporting?

❏ What are some ways to smooth the transition for vendors from group-level aggregate data to client-level data for GLI's ILI's?

❏ How do we conduct data collection on a shoe-string budget?

❏ Will CDC provide the software for a web-based reporting system and assist HD in the installation of the system?

➡ 6 - 9 months
➡ Referred to data management system
➡ Don't standardize

❏ Will CDC fund a position specific for data collection? Without a position, this task would face numerous challenges/barriers related to data reporting (i.e. reporting, implementation, etc.?).

➡ HD can hire someone

❏ How do we collect data on GLI # sessions?

➡ NY responds

Group Three Notes

❏   What it takes to get started – methodology/spreadsheet:

➡   Engaging stakeholders in the planning process, achieve buy-in from those collecting the data from the field. Encourage stakeholders to provide input into what type of data will be collected (bring all stakeholders together)

➡   Need to clarify <u>purpose</u> of data. What the data will be used for helps determine what type of data to collect

➡   Is it possible to collect the data? Attempt to tailor data.

➡   Why should <u>specific</u> data be collected?

➡   Look at existing evaluation tools to avoid duplication in the jurisdiction – who is already collecting similar data locally, within, and across states

➡   Look at what you've done.

➡   Need to establish <u>key</u> data collectors for each organization and establish working relationships.

➡   Ensure data forms get to the HD.

➡   Pilot test tools/train staff to ensure stakeholders understand the instrument.

❏   Reporting: how do we collect data w/o overburdening the contractors?

➡   Is Web-based reporting the answer for CBO's?

➡   CDC or independent jurisdiction WB systems? Hope CDC will get Web-based system up and running ASAP

❏   If using an independent system, it should interface with the forthcoming CDC WB system, ERAS:

➡   Want to utilize a Web system for reporting so data won't seem so overwhelming for providers and vendors.

➡   Seeking uniformity, yet flexibility for states

➡   Optional fields

➡   Individual versus aggregate data for output

❏   How does one collect individual-level data for outreach or is it recommended/useful?

➡   Many do not see value in collecting client-level data (comprehensive info. on individual)

➡   Instead <u>lump</u> characteristics of targeted population in aggregate form

➡   Attempt to collect clean data as best you can (it's the quality of the data – what level of quality is OK?)

➡ Discretion of outreach workers is very valuable
➡ Guam – differed with opinion above due to varied value systems and different populations
➡ Familiarity is key to success
➡ Translation process takes time
➡ Letting RFPs cause significant delays in reporting – CDC needs to understand barriers
➡ CDC changes have tremendous effect on local jurisdictions translating amendments to contractors: when CDC changes definitions, e.g. race/ethnicity, it creates challenges for HD as they work with their vendors to explain the change or new requirements. Often means re-training providers/vendors. Changes have to come in time slots for the HD.

❑ How do we collect race/ethnicity data and be OMB-15 compliant? Also, be understood by state/Fed?

➡ Hardest part is getting data collectors to collect race and ethnicity separately
➡ OMB-15 has many sub-categories identifying race/ethnicity

❑ How can HD assess the accuracy and QA of data collected?

➡ Continuous communication and training with providers – address FAQ
➡ Set goals for completion of data
➡ Must reaffirm to vendors that they will experience change in numbers – this is to help them with the fear factor of not being refunded
➡ Data should not <u>purely</u> be numbers driven; grantor needs to let contractors know due to additional evaluation requirements they will understand if objectives are not met fully (i.e. 500 vs. 560 persons) due to implementation of evaluation requirements
➡ Have a clear understanding that service provision is important and if agencies are not doing what is required, they could lose funding if objectives are not achieved (this must be stressed to vendors and put in writing)
➡ Because of paradigm shift with evaluation guidance – HD must work closely with vendors/providers to keep them trained and informed
➡ Capacity-building is <u>key</u> – must have mechanism in place for consistent training and skills-building
➡ Efficient and easy to use, must have user-friendly data collection systems

❑ Does the state need a programmer to assist with data collection needs and activities?

Concurrent Session Two – Data Collection, Reporting, and Quality Assurance

Tim Quinn
Xiahong Mao-Davis
Cynthia Prather
Hope Cassidy-Stewart

The same presentations were delivered at the beginning of Session Two on Data Collection, Reporting, and Quality Assurance as were offered during Session One with Xiahong Mao-Davis reporting this time on the CDC requirements for data collection, quality assurance, and data reporting; and Cynthia Prather reporting from the Science and Application Team. Hope Cassidy-Stewart again delivered the presentation on the State of Maryland Department of Health. The discussion following the overview presentations included:

Discussion Summary:

❖   An audience member said that she had just moved into a state that needs a great deal of help, and she was not sure that the staff and the computer system were prepared to deal with the Evaluation Guidance. She inquired as to whether someone from CDC could come to the state to help them put the software in place, and show them how to operate it. Choi Wan answered, saying that the ERAS system would be pilot-tested in eight different health departments during which time they would learn what kinds of training and technical assistance might be required. He assured the group that states would be able to use the system.

❖   Tim Quinn commented that there should be a mechanism whereby CDC staff can help state health departments with installing software, working with staff to get them familiar with the software. Choi Wan clarified that as ERAS is a Web-based system, no software will need to be installed. They will conduct pilot site workshops, through which they will incorporate feedback into the guidance materials that accompany the ERAS. These workshops will tell CDC whether the materials will be sufficient to help states navigate the system. Technical support will be available around-the-clock for the system. If the documentation is not at a stage where it can explain the system without training, then they will adapt their approach.

❖   An audience member commented that manuals are often not the best way for people to learn a new computer system; working hands-on is better. Some of the organizations in her state are at a very low level of technical capacity, so they will need some kind of training even to access the Internet. The time that they have before the system is up and running should be enough time for them to make training plans, such as courses at the state college, so that their CBOs will be ready.

As in the first session, Tim Quinn divided the larger group into three smaller ones. This group handled their discussions somewhat differently than the groups in the first session. Each attendee was asked to write his or her most pressing question about data collection on a 3 x 5 index card, then each smaller group deliberated one of the questions. Each group's question is shown followed by its respective discussion.

Question #1

"Concern: with any policy, its power/application is realized through its implementation. I find it unethical for CDC to establish directives with no support: CDC should provide, via contractors, health department on-site TA whenever possible." The writer of the question clarified his statement, saying that sending manuals to health departments regarding directives does not ensure that the departments understand what is expected of them. Without on-site help, they cannot perform as well as they would like. What support can they offer states that do not have computerized, statewide reporting tools?

Discussion Summary:

❖   There was discussion about using CDC consultants to offer advice on the entire health department structure, not just on the Evaluation Guidance. For instance, CDC could help the state epidemiologist integrate data with the HIV prevention branch. Hope Cassidy-Stewart agreed that there might be an opportunity for an integrated system, and that there was no way not to have a consultant.

❖   A group member commented that another RFP was addressing that issue, which he thought was sponsored by NASTAD and CDC.

❖   Tim Quinn pointed out that some states have such small staffs that their operations become a question of what to give up or let slide in developing a system, and outside help is crucial.

❖   Hope Cassidy-Stewart wondered whether a consultant from CDC could come to such programs to assess their data system and needs, and to offer assistance where there are separate reporting systems for different branches of the department. States should integrate care and prevention. They are separate in Maryland, and a model to help them work together would be wonderful, she said. Mr. Quinn made a note of the question, indicating that he would take it back to CDC.

❖   There was discussion of the listserv, which could be a great resource for state health departments to share information and build on their body of shared knowledge. These e-mail lists are relatively easy to manipulate and to filter, so departments can only access

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the information that they need. The NASTAD website also has links to many state health departments, it was noted, and CDC could include a similar section of links on their website. Tom Creger agreed that one of CDC's responsibilities is to keep abreast of such things.

❖   Hope Cassidy-Stewart remarked that NASTAD is under-utilized. She had not known that peer-to-peer health department TA was available. She suggested that perhaps the CDC listserv could include a message board and chat room. If information is archived on the site, then it can be reached easily. Forms could be included in .pdf file format as well.

❖   Another group member added that web-broadcasting is more cost effective than video-conferencing, and could be another great asset to them as they stay informed. It was also mentioned that this technology is aimed more at health departments than CBO's, but that some web-based applications might be appropriate for CBO's to use, with proper training, both on-site and via tutorials.

Question #2

This question focused on the realism of supervising the collection of good data from agencies when people are working for low pay and low benefits and are over-burdened in other areas. The reporting system's accuracy relies on good data at a micro level, and the ongoing interventions have standards. The questioner mentioned that in pilot-testing forms in four different places, his group got four different responses to them. Each state needs to personalize the forms, because certain formats and issues apply more than others. The field workers must have some system of supervision to ensure quality data.

Discussion Summary:

❖   Tom Creger agreed that a data system is only as good as the person collecting the data, and to achieve buy-in, the first person who needs to approve of the system is the person who is interacting with the population, conducting interventions. One of the benefits of going to these people for feedback is that they remind CDC of the behavioral change issues that are sometimes lost in the more "academic" approach to data collection. At CDC, he said they are advocating for forms that will be used, and used correctly. Step #1 is helping CBO's understand why they must collect data in a standardized manner. Then, they can move to more thorny data collection issues. He noted that all attendees of the conference seemed to be struggling with similar issues.

❖   A participant mentioned various public health models that incorporate extensive training programs in the field. Different states have different standards, and a particularly successful program utilizes role-modeling. So often, workers hired to do HIV and AIDS

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interventions on the street lack training and supervision, even though they are well-meaning people. Graduate students can provide a motivated pool of potential workers. Tom Creger commented that sometimes people can be instructed to fill out forms in a certain way and observe certain procedures, but they will not. Instead, they might give incomplete or incorrect information. Experienced field staff understand this issue.

❖ A group member commented that in training workers, it is also possible to establish an ongoing dialogue with them. Some states are creating requirements for certifying workers before they go into the field. She wondered if anyone else had experienced certifying outreach workers creating a baseline of good, prevention workers. Tom Creger agreed, emphasizing the important step of getting buy-in from the field workers. The Prevention Program Branch has struggled with that issue, he said, and he wondered how others have coped with it.

❖ Giving fast, specific time frames for when data reporting – forms give workers more accountability, and the forms can be tracked more closely. When deadlines are early for forms, there is less likelihood that the workers will fill them out in a hurry, right before they are due.

❖ Another participant described a long process of dealing with the issue of training and buy-in of workers. Regional training sessions were a way for them to work directly with programs in areas such as quality of care, definitions, activity types, and data collection. She also said that her department studies the data to find rationales for why certain types of information are sought in a given area. They can then respond to that demand by sending workers who appeal to the needs of the population. They have found greater receptivity to the forms, and fewer errors, by paying attention to these needs. Retention of staff is another issue, so she deals directly with program managers who can teach new staff how to fill out the forms so that they become institutionalized. It is also important that members of the target population see the forms and provide feedback. In general, they try to conduct quarterly assessments wherein they look at projected figures for the year and assess each program's progress. Sometimes the outreach workers need to be challenged about some data, but they are understanding more and more clearly the need for quality data and they understand that their role is central to creating an overall system that helps their target population.

❖ A participant commented that his department is always looking for good venues to use to educate their workers, and often a one-on-one discussion has been successful.

❖ Hope Cassidy-Stewart remarked that when they set out to create their data collection system, the Health Department Evaluation Guidance acted as a justification. They knew that they wanted to evaluate their prevention programs, but they never had the internal support they needed, so the data meant little. It will take them years to get data that is

worth analyzing, but they have been inspired by the buy-in just from the first year of implementation. Their Community Planning Group members are very interested in sitting on the Evaluation Committee. They are, in fact, beyond initial buy-in. Now their CBO representatives are helping them refine their forms.

❖ Reports back to the agencies are key, said another participant, as they receive something for their efforts. Tom Creger agreed, and suggested that health department staff ask agency representatives questions about their reports so that they will see how carefully the data is used and discussed.

Question #3:

The Outreach Prevention Model includes the use of peers; however, bringing in peers creates problems with certification. Training is important, but after they are trained, then at what point are they no longer "peers?" They may lose their effectiveness in the population. There will always be slippage with outreach issues, so using these models is important: there has to be way to calibrate the context of the outreach.

Discussion Summary:

❖ A participant asked whether people would object to certifying outreach workers, and another asked about what happens to the smallest CBO's that do not have the resources to make large changes in their labor pool.

❖ Hope Cassidy-Stewart said that Maryland has a diverse group of vendors and organizations that work at the grass-roots, and need help in a variety of areas. Her department took away their burden of data entry because they did not want to scare away those small CBO's that have such a connection with the community but are "afraid of computers."

❖ A participant said that the overhead salaries and benefits for a basically trained person are more than worth the expenditure, especially considering the impact on the services. Perhaps larger groups can contract out to smaller ones for this assistance.

Question #4:

Client-level data: how do you capture it, and what do you use it for? How do you capture risk assessment, and how are clients kept anonymous?

Discussion Summary:

❖ The group acknowledged the difficulty of this issue. Some departments do not collect

client-level data and concentrate on aggregate data.

❖   A participant pointed out that the main concern with this data is HIV status. These
        clients are not likely to be unique to one agency, but do not have the same identity to
        each one, even to multiple agencies within an agency.

❖   Hope Cassidy-Stewart described Maryland's method for creating unique identifiers. She
        acknowledged that it is not a perfect system, because there is some overlap. Clients must
        not feel at any point that they might be identified.

❖   A group member asked Hope Cassidy-Steward about the feasibility of using data systems
        to see if clients reached through outreach are accessing other services and then trying to
        look at the possible linkages. She replied that they did not feel that outreach workers
        were willing to ask the amount of information that would be needed to link clients. They
        do not want to breach the relationship between the client and the outreach worker.

❖   One participant outlined a program that made clients "members," giving them an access
        card which would keep track of them when they used the Center's services. They saw a
        benefit of participating and being involved. So far, this program has relied on peer
        influence, and it has been a sought-after program with a high number of cases. Another
        person commented that her department had tried a similar management system because
        their clients were very mobile. Clients were assigned a card with a number at whichever
        venue they accessed, and that number was uniquely theirs at any point in the system.
        This method motivated a typically disenfranchised community, she said. Another
        member noted that in his experience, in a small community, the risk of identification
        most certainly keeps people away from programs.

❖   Tim Quinn noted the form's ability to capture new interventions, given that there is a
        place to explain new interventions on the form. Using these miscellaneous interventions
        gives agencies creative opportunities to try out new ideas. Hope Cassidy-Stewart added
        that those interventions are often difficult to measure. They are involved in coalition-
        building, and they are struggling to evaluate its impact and benefits, and how to make
        concrete connections to HIV risk behaviors.

Question #5

*This question regarded borrowing ideas from other disciplines; for instance, from Prevention
Case Management. What if there were a program announcement that would support the
development of an intervention with prevention case management as part of the culture?*

Discussion Summary:

❖   Tim Quinn pointed out that program announcements and projects are often dictated by Congressional mandate. Hope Cassidy-Stewart added that data has an impact on those mandates. Tim Quinn agreed, adding that there are good people and good resources in the field who are using their best efforts to conceive of the best processes. He reminded the group that any data collected that is not needed on CDC's aggregate form should still be kept for possible future use.

❖   A group member commented that his state has contractors that are conducting activities that do not necessarily fit into an intervention plan, such as focus groups. Definitions become a problem in this case because what the contractor calls a "focus group" often turns into a "discussion group" or an "educational session." How can he collect this information? Are there other means of reporting data collection on process objectives? Hope Cassidy-Stewart confirmed that they collect more data than what is required because they try to think about what the state needs, what the vendors need and want, and what CDC needs. She advocated for collecting "what you think is important," keeping in mind that the information can be categorized later.

❖   A participant pointed out that there is an inherent "Catch-22" in collecting and reporting extra information. If a small amount of money is allotted to a project, then the extra work and information may not be easy to get from vendors. Tim Quinn expressed his hope that they would want to provide all of the information that they get.

❖   A participant agreed that collecting more than the required characteristics is advisable for several reasons, including protection. If the model changes in the future, then the system can anticipate different data needs so that the "old" data is not lost in a "compatibility crisis." Tom Creger pointed out that the data can always be collapsed and then reported in subgroups.

❖   A participant described his department's transition from collecting very detailed, client-level data, with detailed assessments, interviews, and risk assessments, to collecting on an aggregate basis. Now they are collecting individual-level, client data as well as aggregate, outreach data.

Question #6:

This question regarded on-line video and whether anyone was using a specific tool for outreach to multiple risks, multiple times.

Discussion Summary:

❖   Hope Cassidy-Stewart said that their outreach does not track multiple encounters with the same person. Another group member tried to track this information, but said that it is

difficult to ask about prior contact with an agency. Tracking the referral system is even more difficult.

❖ Tim Quinn urged the participants to use their Project Officers as resources, and to feel free to ask questions. He also encouraged them to use their colleagues as resources as they all worked through the Guidance together.

Data Management

Facilitator:	David Cotton
CDC Representatives:	Choi Wan, Jaime Altamirano, Xiaohong Mao-Davis
Health Department Peer:	Mari Gasiorowicz, WI
CBO Peer:	Prescott Chow

These sessions addressed data management issues that jurisdictions have faced when implementing Guidance activities. Discussion was around the following questions: Are there ways of easing the burden of data entry and analysis at the program and state levels? How can jurisdictions reduce the lag time in processing and difficulty in providing tailored data reports? How can jurisdictions support CBOs' ability to collect, tabulate, and manage data given frequent staff turnover?

Two sessions were convened for this topic. The presentations delivered as an overview were identical and have not been presented twice. However, the dynamics of each group were different, and the input itself is presented separately.

Concurrent Session One -- Data Management

David Cotton
Facilitator
ORC Macro

David Cotton welcomed the group to the session, noting that it was an opportunity to learn from each others' challenges and successes. He encouraged everyone to share issues and feedback, as well as ways to address those issues. He said that suggestions for features of data management systems would be helpful. These features might include the kinds of reports generated and the nature of interfaces. He posed the question, "If you had unlimited resources, what kind of system would you want?"

Choi Wan
CDC Representative
CDC/PERB

Choi Wan updated the group on the ERAS system, indicating that it is an aggregate reporting system. Eight to nine different health departments will be pilot-testing the system. They hope that the second phase will be even more helpful. He then described another upcoming product – health department software. Local health departments can use this software to organize their CBO or funding agency data to use the data as well as aggregate it for CDC. The system has been delayed, but the time-frame for the software is a six-to-nine month turnaround. By then, the system will be available to health departments, as will training and technical support.

Mari Gasiorowicz
Health Department Peer
State of Wisconsin Health Department

Mari Gasiorowicz said that in Wisconsin, their approach to data collection and management is different from other states. They have standardized forms for everything from intervention plans to data collection forms, and they require all of their agencies to use these forms, placing a heavy burden on them to prepare the intervention plans, decide which type of intervention plan to use, to collect the data, and to enter the data. They are in the pilot-testing phase of a web-based system. Their philosophy and goal is for agencies to be able to use and manipulate their data, increasing buy-in and ownership of the intervention plan and the data, at every level from administrative to outreach. They are also committed to a significant amount of training and technical assistance.

They have several parts to their data collection and management system. They incorporated the CDC Evaluation Guidance into their HIV prevention training and interventions. Within the intervention plan manual, there are seven intervention plans, and training is available either to providers or to the population. She offered examples of their data collection and reporting forms, which their agencies complete as part of their intervention plans. There are tables to describe target populations, including the total number of clients served, race and ethnicity, and HIV-status, if available. Agencies make their expected target populations part of their intervention plan – the basics of who they think that they will reach pertain to data management, especially in anticipated outcomes. Agencies project how many people they think they will see.

The intervention plan is an important piece of the work. She produced a red binder, which contained data collection forms, samples, and instructions. Data is collected on the group and individual levels. In Wisconsin, they collect client-level data. Many states aggregate data, while others keep it at the individual level. The forms in the red binder correspond to the website. Instead of a client code, they use a provider-based code, which includes the initial of a staff

person. This code follows the client within an agency. Client information includes the initial date of service, the source of services, counseling and testing, and other data.

The website can also track prevention case management (PCM) data, noting how many clients participate in a given intervention plan: each intervention plan has a different code. The use of a provider-based code for each client eliminates the need to complete client information more than once: details such as gender, age, race, and ethnicity are held in the client code. There is also space in the forms to note referrals to other services, when the referral(s) took place, whether information was provided or the referral visit was more directly facilitated, and whether it was completed.

The intervention plan tracking also includes services tracking, so it is noted if clients belong to more than one intervention plan. Due to their funding in the state, she noted that they keep more detailed information in this area than other states might have to keep. Each session is committed to the system, including the date of contact, the amount of time spent, the kind of time spent (for instance, face-to-face), the setting, whether incentives were provided, whether goals were set or reviewed. The modules and topics covered are also noted.

In the web-based system, agencies enter their data by intervention plan code, both at the client level and for intervention services tracking for ILI, GLI, and PCM. She then demonstrated the Internet site, asking the group for feedback, as it was still in the pilot-testing phase.

Agencies can enter new intervention plan types, and the forms correspond to the paper forms given by the health department. Intervention plan data includes funding details, such as funding sources and total clients served. Mari Gasiorowicz told the group that there was no way, at present, to sort the clients in any way, such as by client ID or point of entry. As the system is web-based, there is no limit to how many users can use the system at the same time.

She spoke about the department's decision to code their clients using a provider-based code. This system relates more to provider perception than to actual confidentiality issues. Provider codes reassure participants that they are anonymous, despite the many good codes that incorporate a piece of the client's name or use another method for tracking clients across agencies.

Most interesting to their agencies is the report for ILI, GLI, and PCM. This report compares predictions to actual results of the work and tracks programs' progress toward their goals. With this feature, grantees know their status exactly, including client demographics and referrals. The kinds of interventions being conducted are also tracked. Adding narrative is possible as well. Agencies are responsible for logging all of their data by thirty days after the end of the quarter, including a narrative for each intervention plan.

Their grantees have not begun to enter real data, as they are still in the pilot-testing phase. Training and technical assistance on both the intervention plan and the data collection forms have been an important aspect of the health department's work to get the system on-line. They have improved intervention plans, they expect to get better data, and their agencies seem to be committed to the system.

In conclusion, Mari Gasiorowicz gave the group a list of some of her lessons learned from the process:

❏   The project has taken longer than they thought it would, and they are not done yet;

❏   The testing phase is critical; and

❏   Having the paper forms ahead of time was helpful so that agencies could become familiar with them and use them to collect data for subsequent entry into the web-based system.

Discussion Summary:

❖   An audience member asked Mari Gasiorowicz about the cost of the system.

❖   Mari Gasiorowicz replied that the state had a bioterrorism grant under which they are developing a health alert network system. That project has incorporated their reporting system. She asked their web developer to estimate his time spent on the site, and he guessed that his hours of work would total approximately $10,000. Development costs were minimal for them, but the project has taken a great deal of her time and the state epidemiologist's time.

❖   Another audience member asked about the intervention forms.

❖   Mari Gasiorowicz said that when people are doing their interventions, they use the state's standardized forms. There are different forms for clients, services, and outreach.

❖   Another participant inquired as to how their web system related to CDC's ERAS system.

❖   Mari Gasiorowicz said they have an ACCESS database, but she also understood that web-based systems are not optimal for detailed cross-tabs. They manipulate the web-gathered information separately, which allows them to generate CDC reports, which then go into the ERAS system.

❖   An inquiry was posed about the number of providers and grantees that Wisconsin has and about how they feel about the system.

❖　　Mari Gasiorowicz replied that they have about thirty grantees. The time involved has been a problem to some of the pilot-testers, but they are learning how to enter the data fast.

❖　　Another audience member commented that New Jersey has been collecting client-level data for a while. States are in multiple stages, but he urged them not to collect data just for CDC purposes. Their forms include each agency's needs, the state needs, and the CDC needs. With this approach, the agencies get information that they can use and that also satisfies CDC's reporting requirements. Before choosing a system, he stressed that it is important to work with CDC to ensure data compatibility.

❖　　A participant from a smaller state commented that they do not have the in-house personnel resources to draw on to implement these systems. In small states, the three or four people in their office will be putting these systems on-line. He expressed his hope that CDC would remember that states have different levels of resources.

❖　　Another participant added that ongoing technical support for the CBOs is a real issue. Where they expected a need for assistance in using the software, they have found that the needs for assistance are coming in the program evaluation, including definitions and guidance.

❖　　Hope Cassidy-Stewart commented that in Maryland, they were not web-based. The core of any system seems to be helping CBO's understand it and how it relates to them and their projects. The quality of the data depends on the people in the field, and training them takes a lot of work.

❖　　David Cotton added that there are several layers to the work, from working with contractors to assuring quality data input to the issue of the data management system itself.

❖　　A participant said that his state gives reports twice a year and makes comments on progress. Sharing this information with grantees interactively would be a great asset, creating an ongoing dialogue between the progress monitors and the grantees.

❖　　A participant from Massachusetts noted that there are eleven data collection systems being used. She wondered about a possible forum for sharing IT-level information.

❖　　A participant from Minnesota said they found that getting information from the non-technical, evaluation staff to the IT staff was impossible. He recommended that CDC do periodic video conferences for technical people so that they can keep up-to-date on changes.

❖   Hope Cassidy-Stewart suggested that they set up their own conference calls to share information.

Jaime Altamirano
CDC Representative
Technical Assistance Opportunities

Jaime Altamirano said that when a new system is initiated, even if it is designed to improve on an existing system, it is expected that the new system will conflict or clash with the current system. Therefore, as soon as the new Guidelines came, they were prepared for the number of technical assistance requests that came in. The requests came from four aspects of data management:

❏   Generating data: reporting aggregated data to CDC may require changing the states' system of data collection, creating new forms, changing the data collection methods on the state level;

❏   Data entry;

❏   Data validation; and

❏   Transferring data back to CDC.

He reinforced CDC's understanding of the challenges that the changes brought about. Taxonomy and interpretation of the CDC guidelines were the bulk of initial TA requests. Then, requests centered around reconciling the new forms with extant state forms and requirements. Some states had completed development of their own data collection system and were being asked to modify it again. This frustration could sometimes be alleviated by understanding the benefit of a universal method of data collection, which facilitates comparisons of data at the state and national levels.

Instead of dwelling on definitions, Jaime Altamirano focused on the action steps required to report data according to the new guidelines.

❏   Adaptation to the new forms or the creation of new forms at the state level
❏   Changes in data collection methods
❏   Data entry and validation of data
❏   Data analysis and reporting of aggregated data

State health departments are not expected to conduct in-depth analysis on data, but only to report aggregate data to CDC. However, he urged them to consider how their data can be used for their

benefit and for the benefit of their providers and CBOs. They should anticipate further data analysis as they develop their databases.

Data transfer is the last step, and CDC is creating the ERAS system for this reporting. Some states are not concerned about the data transfer process, as the first steps are more important to them. He pointed to Wisconsin's process as a good first step in developing a system for data collection and reporting. Other states are still waiting for CDC's assistance or the software. When a request for technical assistance comes, CDC adapts to the needs and technology levels of each state. Requests come through Project Officers to the Science Application Team.

CDC's software is anticipated in six to nine months. In the meantime, the states and jurisdictions who have developed, or are in the process of developing, their own models, are willing to share ideas about their systems. They can also share experiences, barriers, or limitations in the process. CDC will create an avenue to share that information from state-to-state. Hardware requirements are a capacity-building request, he noted, but he expected that most concerns were with software and with training. Health departments have to collect data from CBOs, taking into account the upcoming CBO guidelines. The system must be compatible with these guidelines and ensure that the CBO and local-level data will be reported to the state level. Each state has its own concerns in this area, so the technical assistance team analyzes each situation when providing technical assistance.

Discussion Summary:

❖   A participant asked, if the software that CDC is developing is similar to Wisconsin's system but not the same, whether they would accomplish similar goals.

❖   Jaime Altamirano indicated that they would accomplish similar goals. They are all trying to develop a system that will help the state collect the right data into the right database that will generate useful aggregate data.

❖   Another participant inquired whether the ERAS system would have a place for a prevention plan.

❖   David Cotton replied that the system does have a place for intervention plan data, but it is not connected to goals or process monitoring data. Data linkage is included at the health department aggregate level, not at each CBO or each intervention level. The new system will address the relationship between the provider and the health department where ERAS is concerned with the transfer of information between the health department and CDC.

❖   An inquiry was posed as to whether the ERAS system had space for client-level data, and a way to enter information about an intervention plan for each of the state's agencies.

Will the system aggregate the data and send it to CDC?

❖   David Cotton pointed out that the new software in development will provide aggregates at the health department level from either client-level or intervention-level data.

❖   Since development of systems takes longer than expected, an inquiry was posed as to CDC's best case scenario of when the software would be available, as opposed to the estimate of six to nine months.

❖   Jaime Altamirano replied that their difficulty was in creating one product that will apply to several states, given the different needs of each individual state. David Cotton agreed that six to nine months is, at the least, optimistic.

❖   A participant asked about the ability of the system to store electronic data since databases can take a lot of space, and systems can crash if they are overloaded.

❖   Jaime Altamirano said he appreciated the importance of the issue. He noted that access is also a concern. Having data entry at different points makes validation very difficult because of different capacities at different sites.

❖   Tim Juday, from Hawaii, asked what health departments should do in the time before the ERAS system is up and available. He wondered whether they should work to develop their own web-based system, or whether they should invest their own resources in developing their own systems. He also commented that the data collection system and the ERAS are illogical from a statistician's point of view. Each locality collects its own data, and when national-level is aggregated, problems are likely to occur with each state's own way of collecting data and its own definitions, regardless of what the CDC says. There are going to be validity and viability problems, and statistical analyses with those data will not mean much, so that policy that comes out of those analysis will be questionable.

❖   Choi Wan replied that CDC would support states that wanted to develop their own data collection systems. They are, however, asking states that might not have that capacity to hold off on creating their own systems until they can be more certain of when the ERAS system will come on-line. When PGO makes an official, clear announcement, then the turnaround time will be very quick, he said. In short, if a state has begun working on a system, then that state should continue. If a state has not begun, then they might wait. He said that the six-to-nine month time-frame was his hope, and that it represented not only when the system would be ready, but also when technical assistance would be available. Choi Wan acknowledged that there were fully aware of the issue of different health departments reporting different data and using different definitions. This is why no aggregate data has been released to date. They do, however, want to test some

mechanisms to unify definitions and systems, hoping that in the future, health departments will come to agreement about definitions. Aggregating information across states and departments makes sense not only for CDC, but also for local governments. At this moment, Choi Wan agreed that there is a danger in aggregating data.

❖ Jaime Altamirano added that states should pursue their own interests in data collection so that they might manage their data for themselves and their localities. It will be beneficial to be compliant with the CDC software as well, so he encouraged states to keep both their local needs and CDC requirements in mind.

❖ An inquiry was posed as to when the RFP for data systems would be released, and for what period of time that funding would be available.

❖ Choi Wan answered that they hoped that the announcement would come very soon, maybe by July, 2001.

❖ An inquiry was posed as to whether CDC is using the intervention plan data that thirty-six jurisdictions (just under half) were providing.

❖ David Cotton replied that they were using the data for process monitoring. The speaker noted that his state does not have a system, and so he and a colleague worked many hours to translate their data into reportable form for CDC. They were proud of their efforts, but were disappointed to learn that not all jurisdictions reported, rendering that data less-useful.

❖ Choi Wan said that the percentage of health departments who reported was from two weeks previously, and they had received information since then. He agreed that more health departments must report process monitoring data.

❖ David Cotton added that CDC is actively involved with the data that they got on intervention plans and that they plan to do the same thing with process monitoring. They recognize that there are going to be unique aspects to the data received and hope for fuller data the "next time around." The numbers are too small at this point to do something that is interpretable, and process monitoring data are too new to have analyzed.

❖ Choi Wan said that CDC had given the jurisdictions feedback on their intervention plans. In the area of process monitoring, they are examining the discrepancies between the data provided and what the Guidance suggested. In the long run, they hope to help keep the information good and the turnaround time fairly fast.

❖ An inquiry was posed as to whether CDC was sure that the CDC health department

management system would not one day be mandated for all jurisdictions. Since this participant was developing his own system, he hoped to avoid spending time and resources developing a system, only to find out later that, for standardization purposes, all states would be required to follow CDC's system.

❖ Choi Wan stated that the CDC system would not replace any systems that have been developed or are under development by health departments. They see the need for a CDC-created system and the accompanying TA, so they want to provide the product to states that do not have the capacity to develop their own systems.

❖ Jaime Altamirano added that CDC has a problem with epi-profiles, which are different from one state to another, so it is not possible to compare profiles across states. Whatever system is used, he stressed that there must be a core of standard information that states have in common.

❖ It was noted that there are two pieces to doing work on the web. The web interface which Mari Gasiorowicz showed them is separate from the underlying database. CBO's work with the interface, and the database is often determined by the health department's IT department.

❖ An participant commented that in Florida, they were able to complete their intervention plan data. It took hours, because they do not have a system, and they were still collecting data using their old, pre-Evaluation Guidance method. This method did not yield the cross-tabs that CDC wants, but they worked to create them. The data is flawed, for instance, a contract written to reach "Black men" in the intervention meant that the health department had to guess the ages, risks, and other attributes of that population for that study. She hoped that those data would not be used to analyze activities in Florida. Reporting the process monitoring data, then, seemed pointless because they had not collected data the right way and the data would have meant nothing. She hoped that CDC would acknowledge that states without a system would not be able to provide good data, and advocated waiting for a good system rather than filling out the forms for the sake of satisfying the requirement.

❖ David Cotton asked whether they now have a system in place for data collection that will, next year, yield data that will be better. She replied that they would for the next progress report because of the new cycle of providers. David Cotton asked whether other jurisdictions were in similar situations, having to wait for cycles to be complete before good process monitoring data can be collected.

❖ A participant noted that developing a database depends on variables, and she wondered if CDC staff could say when the variable definitions would stop changing.

❖ Jaime Altamirano sympathized with the question, adding that taxonomy and definitions can be a large problem. The simple definitions from the Guidance were questionable in certain jurisdictions, and standardization was difficult. CDC gets regular, new mandates from Congress about how to address certain populations, and they have to adapt to those changes.

❖ Hope Cassidy-Stewart noted that in Maryland, they collect more specific information that what CDC wants, so that when taxonomic changes occur, they can collapse their data differently. The interface that the CBO's use does not have to be what is sent to CDC.

❖ A participant asked that the CDC data collection and reporting system give states flexibility. With flexibility in collecting process data and in, for instance, individual client-level data, states can work with their CBO's to collect data in the best way possible and still be able to be aggregate into the appropriate categories.

❖ Another speaker advocated for flexibility in such areas as cross-tabbing referrals. The system should serve the jurisdiction and also CDC's expanded requirements, with the potential for adding variables that are not part of the Guidance, but which states may need and use.

David Cotton then led the group in a brainstorming session of characteristics of an ideal data collection and management system. The participants generated the following list:

❏ The system should accommodate storing data.
❏ Data should be reportable at a local level.
❏ Quality assurance is an important component – what is entered at the micro level affects the macro level.
❏ GIS information is very useful to CBO's.
❏ Reports should be able to be sorted by client code, et cetera, in the interface. Also look at how client files are arrayed in the system.
❏ The system should coordinate with HRSA, SAMHSA, CSAP, and other agencies to which CBO's are required to report so that separate collecting of information does not have to occur.
❏ The system should have the ability to trace clients across agencies. This is difficult, but critical to see how the client's treatment goes and to trace the impact of various agencies on a given client. Data collection for outreach, in particular, is a difficult issue. One state has index cards that outreach workers use for notes, and outreach has the widest variability in data. There are ways to code client data that will assure confidentiality.
❏ Multiple and simultaneous users should have access to the system, and the system should be able to support them.
❏ Many CBOs do not have the capacity to use a web-based system, so CDC should develop a product that is compatible across machines with very basic technology levels.

❏   Perhaps ILI and group-level interventions should be the focus, and outreach can come later in the priority use of resources.

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<u>Concurrent Session Two -- Data Management</u>

</div>

David Cotton
Choi Wan
Mari Gasiorowicz

Each of the same speakers delivered the same overview presentations, so they are not repeated here. However, the discussion periods following each presentation have been documented:

<u>*Discussion Summary:*</u>

Following David Cotton's and Choi Wan's Presentations

❖   A participant asked whether the system would allow a user to pull specific information such as how many African-American men were served in a given region or in an entire state since this information would be helpful for program planning purposes. Choi Wan replied that one of ERAS's options will be for health departments to be able to access their progress in that manner. He noted that different health departments use different taxonomies, so that feature will not be available on-line, but they will be able to have the information for their agency. ERAS will allow any jurisdiction to access information that they want, bearing in mind the analyses that health departments specify.

❖   David Cotton pointed out that one of ERAS's limitations is that it is only a way to transfer a jurisdiction's aggregate information to CDC. It cannot look at parts of a jurisdiction, i.e. South Georgia versus North Georgia. The health department software that CDC is talking about developing might allow data stratification, he said. Choi Wan agreed, adding that individual client data would be within the health department's database, not ERAS. Their intention is to give health departments different types of information in the same table for in-depth analysis, incorporating different types of evaluations.

❖   Given that their department is devoting resources to a web-based system, one participant inquired as to whether they were better off to wait for the CDC system, avoiding training issues involved with switching systems. Another group member was in the same situation, adding that compatibility with ERAS is an issue, as is the possibility that reporting requirements could change, which could prove to be a problem if the health department's system is not conceptualized in a similar manner to ERAS.

❖ Jaime Altamirano responded saying that health departments that are already developing their own system are thinking not only that they must comply with CDC requirements, but that they must consider the data needs of their other funders and of their state's and CBO's needs. They are, therefore, developing database systems that are much larger than what CDC may require. If that is the case, then waiting for software that only complies with CDC core requirements may not be satisfactory because of your own state's needs, he said. Waiting until the CDC software comes out to think about those extra needs might not be advisable. States that are working on databases now must remember to collect above and beyond CDC's requirements to ensure that time is not being wasted. Some states have the capacity to develop their own systems, and have done so, while others do not.

❖ David Cotton said that there are multiple funding agencies for whom health departments manage data. Some states are anticipating all of those needs and integrate them into a single system. "If there were a system that only managed the CDC Guidance data, would that be helpful," he asked the group? The "closed" or "open" nature of that database is a question. An audience member replied that there are other considerations, including resources and other constraints. Experience of staff is an issue, and using globally-developed software means that technical assistance and updates are available. There is an ongoing investment in making sure that the software system runs smoothly and keeps pace with changes in the Guidance or changes in CBO's. Depending on vendors for these issues can be expensive and a negative experience.

❖ A participant asked whether the CDC program would integrate other systems such as MIS. Choi Wan stated that if a health department has the capacity to do so, then it should create its own system, ensuring that this system can "talk" to ERAS. Each health department has its own factors to consider in making this decision, he said. Upgrades and changes are CDC's responsibility. He told them to wait a few months, unless they were in a hurry, to see how the system takes shape. They should see if the system is something that they can use. The software system is not crucial. It is the data collection mechanism that is crucial, that has buy-in from CBO's and agencies. CDC has the long-term vision that states may be able to link their surveillance, care, and prevention data to allow them to have a comprehensive way to examine implementing programs for their local epidemic. To make this vision a reality, the IT will have to be consistent. CDC is having dialogue with HRSA and other agencies regarding this issue. There are no immediate plans to make system elements the same, but they may be compatible for analysis. The data elements defined by OMB should be the same.

❖ An inquiry was posed regarding compatibility of New York State and New York City. Choi Wan commented that the systems are not compatible at the moment, but that there are common elements. CDC and HRSA are aware of the discrepancy and are having conversations to find consistencies.

Following Mari Gasiorowicz's Presentation

❖   A participant asked about entering a narrative progress report. Mari Gasiorowicz replied that they are trying to keep narratives small and focused just on new information that is part of the intervention. For the first year, the state health department enters the intervention plans for the grantees, and then they fill in details.

❖   Another participant posed a question about budget reports. Mari Gasiorowicz said that they do not reimburse agencies based on expenses. They are paid monthly, and do not have to report actual expenses.

❖   David Cotton mentioned the ease of the transition from paper data collection forms to the web-based forms. He asked Mari Gasiorowicz to comment on the process that the health department went through to arrive at the paper forms. The forms are still in the pilot phase. They got more input on the intervention plan forms than on the data collection forms. They conducted two days of training on the data collection forms, and then a conference call combined with web-based training prepared agencies for the web-based versions of the forms.

❖   Jaime Altamirano asked Ms. Gasiorowicz about difficulties that she found in converting from old forms to new ones, and whether it was easy to integrate the new guidelines into the old forms, or if they had to create completely new forms. Mari Gasiorowicz replied that they created new forms, but they retained some elements from previous ones. The new forms are much cleaner. They have found the intervention plans and the intervention population combination to be very successful and clear to people in their state.

❖   A participant inquired as to whether they submitted their data or their projections of process data to CDC. Mari Gasiorowicz replied that they had not, as they had just completed training and had their prevention plans approved.

❖   Another participant asked about the state's prevention planning group. Some states have regional planning groups as well, and one of their issues with the guidance tools was wanting to capture how many times they meet on the forms. They felt that those meetings were an important part of what they do. Since they want to capture that information, the state has complied and recorded that infrastructure activity in the "other" category. Mari Gasiorowicz commented that they had funded some CBO's to provide technical assistance to other CBO's or providers, so there is a way to record types of activities such as task forces, events, mini-grants, et cetera. They asked their agencies to classify their activities into one of seven categories, eliminating the "other" category.

❖   Mari Altamirano spoke about developing forms for data collection and quality assurance. First, he discussed collecting data from outreach workers on their interventions. He talked about whether the forms were filled out immediately on-site, or later via recall. If the whole system works from the field perspective, then they have to think about measuring the quality amount of data collected on the street level. From the street, data then goes to the CBO, which reports to the health department at the regional level, which reports to the health department at the state level, which reports to CDC. At each level, the data reporting should be comparable. The forms must be easy to use at the street level, but must also collect enough information to be aggregated.

❖   A participant pointed out that technical assistance and security of the website would be two important issues.

Following Jaime Altamirano's Presentation

❖   Mari Gasiorowicz commented that there are a number of states that have data collection systems that are up and running.

❖   David Cotton encouraged group members to talk about where they are in their development of data collection and management systems, including their work with their CBO's and agencies, technical capacity, developing new forms, and other issues.

❖   A representative from North Dakota said they work on a small scale, collecting their data on paper. They have minimal grantees, and they have no CBO's, so their interventions are limited. She can foresee the development of a standardized form that the state can use with each of its contractors. At present, some only submit progress reports, so she hoped that they would create a standardized form and then do the data entry. David Cotton pointed out that because of the nature of the state of North Dakota, resources are centralized, and data entry management at the health department level is a logical direction. She said she will have to develop her own form, keeping in mind how overburdened her grantees are, being local public health organizations. Anything new must be approached carefully. They are already submitting data through a lab, so she can incorporate that system into her forms.

❖   A representative from Nebraska's said that they are in the middle of their first year of trying to implement the standardized data. They adapted an extant program. They have distributed the requirements for data to their grantees, who will then send the data to the health department for data entry. They do not have high expectations for the first year's data, but they are getting used to the requirement. Their ultimate hope was to have a totally web-based system. In their last round of RFA's, they included a capacity questionnaire. At a minimum, each Project Coordinator must have computer software, hardware, and Internet access, so each grantee does have that technical capacity. To encourage grantees to think about a web-based reporting system, the health department has offered the benefits of those reporting abilities. Their TA will have to include these benefits, including instant report generation. She will also include how they can use the data to apply for additional funds. The department itself will need TA about the data and how its validity can be assured. They have explained the changes by "blaming CDC," which the grantees seem to accept. Jaime Altamirano pointed out that CDC often has to respond to Congressional mandates, especially in the area of definitions. The participant from Nebraska assured the group that they ultimately blame Congress when asked for accountability.

❖   A representative from New Hampshire said that they are at the paper level, but are hoping to have the new system in place by July 1. They standardized their reporting forms at the end of 1999, and grantees have given useful feedback on the new forms since then. He believed that his state would benefit from being able to show grantees their progress, the ability to interpret data, and how their grant money is being spent. All of their agencies have Internet capability, which will help them go on-line. They seem to be nervous about web-based reporting and do not seem to understand it, but they do not like having to submit forms. Having access to the information for grant-writing purposes as well as for performance assessment is interesting to them. The agencies are currently giving feedback on reporting mechanisms, he added. They will have access to their own raw data.

❖   Another participant's state introduced the idea of new evaluation items at their state prevention meeting. After that meeting, they assembled their contractors and brainstormed what data they wanted to collect. They then reconciled those requests with CDC's needs. All of their contractors are reporting on the resultant forms, and they are considering a web-based system. They sub-contracted with a local university to work on it. They have had few problems with the reporting forms, but don't anticipate many problems with converting to a web-based system. Because they got buy-in from field workers into the forms, some directors of agencies are worrying about training, time spent, and dollars involved in the conversion to the web-based system. Their contractors all have access to the technology, and directors are being motivated with the promise of getting data back. Peers also motivate them to stay engaged in the process.

❖   A participant from San Francisco showed her draft forms. Their outreach forms include client-level data so that they can track clients that have multiple interactions. Risk behavior information is included. In their single- and multi-session workshops, they collect information beyond Guidance requirements so that they can better describe the epidemic in San Francisco. They are using paper submissions at present, and the new RFP's incorporated documentation needed to fulfill the Guidance requirements. The program managers and the planning unit take burdens off of the agencies by helping with the intervention plan and the monitoring and contract process. Their PCM forms include a quantifying question so that they will know which service a client received, eliminating the need for different forms. They have had difficulty deciding what to put on their Health Communication Information form, so they used the CDC requirements and expect to add more elements later as they learn what will be meaningful to them. They are hoping that the state will give them a copy of their database, which is in development. Issues are related to matching criteria with the state, she added.   Regarding culturally-appropriate outreach efforts, they are in the process of translating their CTR forms into Spanish, and that they have other languages as well. In terms of specificity for different populations, they have had to make their standardized forms as minimal and as encompassing as possible. The agencies will have to create forms that take the CDC requirements and add to them.

❖   A participant from Oregon was excited to be starting from a blank slate. Oregon does not have a history of data collection, so there is no understanding of the taxonomy; there are no standardized forms; and he has the task of designing the system. He was glad to have met people from other states from whom he could learn.

❖   Another participant said that they had gone to a dual system, creating standard forms for health education and other activities. The process was collaborative, so they have buy-in at the local level. They use a combination of paper and electronic forms. They have centralized data reporting and are building a web-based system. Access to this data in de-centralized systems has been slow, she said, which has been a problem. Their grantees understand that this reporting is part of their contract requirements: memoranda of understanding have been helpful in making grantees understand their expectations and what they can expect from the health department. In the next round of contracts, they will require an Internet service provider and powerful computers. Becoming cohesive has taken time, and more minor modification of some forms will be necessary. They collect aggregate data now, but the cross-tabulation tables are becoming unwieldy. Agencies will be able to access this information via the web eventually which will help.

Intervention Quality/Scientific Basis

Facilitators: Qairo Ali, Ann Ussery
CDC Representatives: Marlene Glassman, Charles Collins, Dale Stratford
Health Department Peer: Sandra Klocke and Nancy Jo Hansen
CBO Peer: Mark Colomb

These sessions addressed ways health departments can document the science and justification of interventions to fulfill CDC's evaluation requirements for intervention plan data. Participants discussed such issues as: What is the minimum level of acceptability for scientific evidence and justification? How do you document "validated program experience?" In what ways can logic models and program theory be used to provide evidence or theory for interventions? How can the language in RFPs facilitate the collection of quality intervention plan data? When are good times to make changes in intervention plans? This session was convened twice, with some variations in both presentations and discussion.

Concurrent Session One – Intervention Quality/Scientific Basis

Qairo Ali
Facilitator
CDC/PPB

The facilitator, Qairo Ali, welcomed participants to the session and shared her expectations for a fun and interactive meeting. She then briefly reviewed the three main session objectives, which were to:

❏ Become more familiar with CDC's requirements for documenting the evidence or theory basis for interventions and their justification for application to the target population and setting (intervention quality/scientific basis);

❏ Learn how health department colleagues are securing information from their grantees on intervention quality/scientific basis; and

❏ Learn various methods to assure high quality, "scientifically" based interventions.

Qairo Ali then explained that the objectives would be accomplished through the use of several activities, including:

❏   An overview of where the CDC currently is with regard to intervention;

❏   A presentation by a health department representative describing a personal experience with intervention;

❏   A presentation by two CDC representatives, members of the Science Application Team, explaining one approach for improving the quality of intervention;

❏   A group activity, which would allow participants to meet each other and share information.

Marlene Glassman
CDC Representative
CDC/PERB

Marlene Glassman, CDC representative, spoke about what the CDC wanted to gain from the meeting. She briefly reviewed the Intervention Plan Form, specifically noting the main changes to the ethnicity and race categories. She said that the form related to intervention planning for the upcoming year. She explained that her focus would be on the second page of the Intervention Plan Form, specifically, boxes seven and eight. She said that "intervention quality/scientific basis" referred to "the evidence or theory basis for the intervention and justification for application to the target population and setting." She noted that the form asked for an indication of evidence or theory basis and if the intervention is justified for the target population and setting. She said that box eight referred to the service delivery plan.

Marlene Glassman then summarized what the CDC wanted for the issue of scientific basis and quality of interventions:

❏   A determination about the sufficiency of the evidence used in the development of each intervention: evidence or theory basis for the intervention;

❏   A determination about the intervention's justification for application to the target population and setting;

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❏   A determination about the sufficiency of the service delivery plan. She explained that the service delivery plan should address such issues as:

➜   Format, setting, content and delivery of the intervention
➜   A realistic plan for reaching the proposed number and type of clients
➜   Provider training and supervision
➜   Quality assurance and accountability mechanisms

Marlene Glassman acknowledged that the CDC does want a lot of information, although she said that they do try to provide helpful resources. She mentioned that some of these resources include Volume 1 of the Health Department Evaluation Guidance, Volume 2 of the Supplemental Handbook and forthcoming information on documenting evidence, which would be provided later in the session.

Marlene Glassman said that health department staffs have been working on this for the past year and already have some knowledge of the process. She said that she has seen creative and effective ways of providing the necessary information.

Molly Herrmann
Community Planning Coordinator
AIDS/HIV Program - Wisconsin Division of Public Health

Molly Herrmann said that while she is the Community Planning Coordinator, she has also been pulled into evaluation. She said that her presentation would cover how Evaluation Guidance has affected Wisconsin, and also what they have done with quality and scientific basis. She explained that she would begin by speaking about their system prior to Evaluation Guidance.

Steps Toward Improving Interventions Prior to the Evaluation Guidance

❏   Systems of support, including:

➜   An Evaluation Work Group;
➜   10% evaluation requirement on work plans from grantees;
➜   One full-time evaluator plus portions of other staff;
➜   Contracts with some Wisconsin community based organizations to provide technical assistance and evaluation background to other CBO's (generally minority CBO's);
➜   Evaluation of Prevention for HIV-Infected Persons Project (PHIPP) by Center for AIDS Intervention Research (CAIR).

❏   New forms for grantees to explain the distinction between "contacts" and "interactions." She said that a "contact" is a typical outreach encounter, usually very brief, while an "interaction" generally takes place in a one-on-one or group setting where the participant demonstrates some sort of behavior (rather than simply listening or observing).

❏   "Less is more" message to move away from number orientation and toward interactions. Contacts are used as a bridge to pull people into more intensive interventions.

❏   Philosophy that grantees will enter and use their own data.

Chronology for Implementing Evaluation Guidance

❏   3/00 - Attend Evaluation Guidance training in Atlanta.
❏   3-4/00 - Develop plan for implementation of Evaluation Guidance in Wisconsin.
❏   4-5/00 - Discuss Evaluation Guidance with the Community Planning Group (CPG).
❏   5-8/00 - Rewrite CPG plan to incorporate populations.
❏   6/00 - Discuss Intervention Plan with Evaluation Work Group.
❏   9-11/00 - Two-day mandatory training for grantees (introduction to population intervention taxonomy and intervention plans) and seven technical assistance meetings with agencies to receive information and incorporate it into intervention plans.
❏   12/00 - Grantees submit intervention plans (many went past the due date).

Ms. Herrmann said that they have received positive feedback from grantees on the new system. Previous work plans were very broad, and now they provide more structure and examples. She said that future plans include an RFP to be released this summer, as well as new contracts, based on the RFP, beginning in February of 2002.

Intervention Plans Training and Technical Assistance

Ms. Herrmann said that they provided technical assistance for the intervention plans because they were asking their grantees to buy into a completely new form that appeared to be a lot of work. The two-day training helped the grantees, as well as the on-site meetings. She said that a lot of people were not at the two-day training and, therefore, some of the discussion at the on-site meetings dealt with clarification of the populations and interventions, and figuring out solutions for combining efforts and consolidating plans.

She said they were able to give some guidelines for consolidation, such as having one FTE work on two plans. Each intervention plan then received two to three rounds of feedback, which was a long and tedious process. Some of the feedback given to these plans was that they were actually not fundable as written. Since they were already in the funding cycle, they were not going to de-fund anyone; however, they were able to send a strong message about making changes to these

interventions.

Population/Intervention Summary Table

Molly Herrmann said that participants' packets included a one-page summary of the population/intervention table. She said that this was the meat of what they first introduced to their grantees to get them to buy into the system. The table includes interventions as of April 2001; however, she did note that some interventions have dropped and others have been picked up. She said there are approximately 90 intervention plans from across the state with approximately one-third Group level, one-sixth Health Communication/Public Information, one-sixth Counseling/Testing and the remainder broken down by population of:

❏   34% MSM & MSM/IDU
❏   30% Heterosexual risk
❏   7% IDU
❏   7% General population
❏   22% Various populations (CTS, capacity-building)

She explained that Wisconsin was a state where heterosexual risk was over-funded. They tried to shift people more toward the MSM and MSM/IDU categories, as well as addiction drug use on its own. As far as heterosexual risk, they used CTS definitions as a basis for defining low, moderate and high risk. They told their grantees that if they serve people with opposite sex sexual partners, who are not injection drug users, then they should focus on the partners-of group. These include partners of MSM, partners of injection drug users and partners of those with HIV. They also included some of the moderate risk CTS definitions, such as a person who has been forced to have sex, sex while drunk/high, having an STD or being a sex trader.

Molly Herrmann noted that there was a lot of discussion about multiple partners and that many could not buy into it because the boundaries were so vague – did it mean more than one partner during a lifetime or lots of partners in a year? She and her colleagues decided not to reinforce a subjective belief and kept it out. She also said that they changed "mother at-risk for HIV" to simply "a pregnant woman with HIV."

Intervention Plan Forms

Molly Herrmann said that the form she was describing is the most often used two pages in the plan from the Community Planning Group. She said that they frequently refer people to it when they have questions about how their clients fit in. They separated the interventions into the following categories:

❏   Individual
❏   Group

❏   Prevention Case Management
❏   Outreach
❏   Counseling/Testing
❏   Capacity-building (to agencies or populations)
❏   Health Communication/Public Information (separation of WHIRC)

She explained that the Wisconsin Hotline Information Resource Center (WHIRC) is very different from a lot of the other HC/PI that is done, given that a lot of the other HC/PI entails handing someone a brochure or doing a brief one-on-one. That is why they decided to keep the WHIRC on its own. A couple of exceptions included Partner Counseling Referral Services (because these are not performed by grantees in Wisconsin), and community level interventions. They decided that a lot of the things that were being defined as community level interventions were really something else – usually either outreach or HC/PI. She explained that they did not want to have a vague list for the grantees, and so they decided not to include it.

Molly Herrmann then pointed out the Logic Model sheet that organizes what things need to be included in an intervention plan for it to work and also what the state needs in order to know that it will work. She noted that the last row contained corresponding parts of one of their intervention plans.

She then went onto the example of a Group Level Intervention Plan Form and indicated that most questions asked of them and most revisions that grantees got back had to do with Section (6). She said that the form has been revised and is currently up-to-date, and she walked through the beginning section of agency information. She said they added the organizational profile to have the agency talk about their capacity to serve in general, not necessarily their capacity to do a particular intervention, but to do other things (fiscal management) to ascertain whether they are a solid and grounded agency.

She moved to Section (6) relating to need and justification. She explained that they included a separate form with examples and instructions in order to minimize the appearance of a confusing, instruction-clogged form. Discussion of Section (6) was broken down into the various sub-sections.

Section (6A) "Identified need for reaching the specified population" – She said this essentially means – "Why does this group of people need some sort of HIV services?" She said grantees could use resources, such as epidemiology data and focus group feedback to determine the need for outreach.

Section (6B) "Evidence basis for the intervention" which means – "Why is this intervention effective in general?" They referred a lot of grantees to their community plan because it had been written with all of the evaluation guidance taxonomy in it and they could easily direct them to specific citations. She said that what used to happen is that they would say, "group level

works" and grantees would submit a plan saying, "group level works." Even though they might be telling grantees where to look for citations, she said a lot of citations came in that were not from the plan and, therefore, the previous circular process was improved. Some had been using scientific basis the whole time and they hadn't been asking in such a way that grantees would indicate that.

Section (6C) "Justification for using this intervention for the specified population" is essentially a combination of the previous two sections. She used an example of knowing that MSM needs some sort of intervention and that outreach has been proven to work. Now, she said, this section means "Why should you put those two together?" Why these people? Why this intervention? Why did you put them together? She said an example might be using feedback from outreach they've been doing with women who indicated that they'd really like a sit-down, group-level meeting once per week where they could feel safe and bring in refreshments.

Molly Herrmann said that Sections 6 (A), (B) and (C) were definitely the most confusing for the grantees. She said they re-wrote the instructions to simplify what they were asking for. She said a lot of times grantees would have the correct information in the wrong sections.

Section (6D) "Anticipated measurable outcomes" has changed a lot since last year in that they've added more guidance. In previous years, it only read "anticipated measurable outcomes" with an open box. They they decided to name some things that might happen in a group session. There would be some people that were contacted to be in one; a smaller group would come to at least one; some would come to at least three and so on. She said they are asking them to predict what might happen as a result. She noted that the number tension was reduced because it is okay that the number gets smaller down the line. She said that ten participants out of 100 is considered reasonable and they provide a place to at least indicate that 100 people were contacted in order to give the grantees some credit.

Molly Herrmann then explained that Section (7) was intended to be very brief, especially the "content/messages" section of (7A). She said that listing a few key phrases of what they might talk about is sufficient for this section. She noted that Section (7C) could be tied back to Section (6B) in explaining how they will find out what the outcomes are. Section (7E) was intended to move away from long, drawn-out work plans that simply indicate "on-going" for everything. She said the instructions actually tell grantees to only list plans that have dates. She said the "on-going" plans don't help with capturing concrete results.

Molly Herrmann said she looked at about one-third of the intervention plans and gave feedback on them. The overall feedback they've heard has been positive, even though it looked like a lot of work, and it was tedious to go through the training. However, it allowed them to go out to their grantees offices one more time to do TA in the fall. She said that the more help they gave the grantees, the more accepting they were of the forms, and that it really looks like they do more, and they can really show what they're doing.

In conclusion, Molly Herrmann said that the result of Evaluation Guidance in Wisconsin is that they waive this foundation for the potential RFP. She said that implementing the Evaluation Guidance has required a significant amount of resources and time because it takes a long time to review 90 intervention plans, especially since some went through as many as four revisions. She said the grantees have varying capacity to use the intervention plans and data collection forms. It's not always that they are not up-to-speed, but it could be computer-related or other concrete forms of lack of capacity. The grantees seem to prefer the intervention plans because there are concrete boxes to put things in, and it looks like everything grantees are doing is actually recorded.

Discussion Summary:

❖ There was a question regarding whether the form would be a substitute for a proposal or if it would actually be used in addition to a proposal. Molly Herrmann responded that if the RFP goes through, this would be a self-standing document. She said she would submit this if she wanted to do, for example, group level for women – there are sections about agency background, population and how the intervention would be conducted. They beefed it up a lot so that it could be used as a self-standing proposal. She did point out that there are certain sections they could repeat, such as the agency section. If an agency was submitting several of these, they might have to cut and paste particular information.

❖ A question arose about whether or not this would be an annual plan. Molly Herrmann said that it would be an annual plan, just like the work plans were before.

❖ There was an inquiry related to the average number of intervention plans per agency. Molly Herrmann gave an example from the Northern Region AIDS Service Organization, which indicated that they have two staff and five intervention plans. Another public health region has three or four staff and seven, eight or nine intervention plans. She said they try to get no more than two to three intervention plans per person and that it really depends on the size of the agency. A large agency, The AIDS Resource Center in Milwaukee, has 19. She did point out that these included sub-contracts, and that agencies that were sub-contracted through one of their direct contracts also filled out the forms.

❖ A question was posed about those grantees that did not have strong theory based or evidence based interventions. The participant wanted to know what types of agencies they were, what populations they were working with and what type of support they received. Molly Herrmann said that, for the most part, the AIDS service organizations "got it." She did say there were a few CBO's that needed a little more assistance and that these tended to be those organizations that were serving what they defined as "heterosexual risk." However, they were serving questionable populations, such as

school children and young, pregnant women. She said that if someone said they worked at a community center, there needed to be justification that it wasn't simply because there were a lot of kids in the neighborhood, but that there was a high STD rate or evidence of a lot of risk behaviors or other factors. She said that it was a mix between the AIDS service organizations and some community based organizations. The only intervention plan that she passed with no corrections was from a sub-contract agency that works with people with developmental disabilities and it was only for $8,000. She said they got it and had all of the evidence. They did make themselves very available for technical assistance and explained that there are also two CBO's in Wisconsin, one of which is the Black Health Coalition, that are actually paid to provide technical assistance to their CBO peers.

❖   A question was asked about how identifying need from Section (6A) relates back to the RFP itself. Molly Herrmann said that the Community Planning Group did a priority setting process over the winter that resulted in percentages of how the council thought that resources should be allocated to different populations. She said they over-shot epidemiology data in a positive direction. She gave an example that the general population in Wisconsin is 90% white and 10% minority; however, the epidemiology data shows that over 50% of the new infections are among people of color. The council recommended that 76% of resources should go towards people of color and 24% towards non-minority individuals. The council made a strong statement that challenged them toward the trends, rather than the data. They didn't do any interventions, but instead only did priority setting for populations and sub-populations because their populations are behaviorally defined and some sub-populations talked about minorities and different age groups. If the RFP goes through, the council's recommendations would be used as a guideline for how they would like the money to be spent in Wisconsin. The council set priorities that will inform the next funding cycle directly.

❖   One participant inquired about whether the agencies must report and justify accomplishments from previous funding. There was a concern about grant review committees not receiving that data and, in turn, approving plans that do not impact a wide population. Molly Herrmann said that they do receive quarterly reports from agencies to see if they are on target for the year. She noted that new intervention plans and work plans have been submitted annually, but it was a four-year funding cycle. They'd need a very good reason to de-fund an agency because they are already in a four-year contract situation. Having agencies submit a new plan each year gives them the opportunity to re-write those that would not be considered for funding.

❖   A question was asked about whether or not categories of evidence were actually developed for Section (6B). Molly Herrmann said that there were five or six people who reviewed the intervention plans and a process of acceptability. It eventually came down to herself and one other person doing the final check on the plans, and they worked very

closely. She explained that they were not prepared for how much technical assistance they were going to have to give and they didn't have much time between the September training and when they actually went out. They tried to overlap during the technical assistance portion to include one new person and one familiar with the process to maintain consistency.

Charles Collins
CDC Representative
CDC/CBB

Charles Collins indicated that he and Dale Stratford would be facilitating an informal dialogue, in which they wanted the participants to be active, about eliciting the scientific basis or evidence basis for particular programs. He distributed a handout that illustrated four patterns that frequently happen with evidence based programs:

❏   *Formal Theory:* Charles Collins explained that this is the path of taking formal behavioral theory – transtheoretical, health belief model, stages of change – and using that theory to take the pieces apart and design program elements around those pieces of the theory to create a prevention program.

❏   *Evidence-Based Model:* Charles Collins said that the CDC has invested greatly in this path and through the process of the Synthesis Project, they were able to identify programs that worked. They published a document called The Compendium of Effective Programs and explained that people are taking these programs and replicating them.

❏   *Replication of a Program with Adaptation:* Charles Collins said that when effective programs (such as The Popular Opinion Leader, Voices and Empowerment) come to the state level, the funding that CBO's get to implement these interventions is not nearly as great as the funding that the original researchers got to do the research. He said it is simply a reality of the situation and that frequently the CBO's have to adapt or tailor the original research to fit their population and resources. He said these two paths have to do with replication and then replication with tailoring.

❏   *Implicit or Informal Theory:* Charles Collins said that they have found that, frequently, CBO interventions are not started with formal theory or with The Compendium of Effective Programs, but are started with the common sense assumptions of the community – with the community thinking about the problem and thinking about how they will go about doing this.

Charles Collins said that of these four paths, formal theory seems to apply more to new programs and informal theory seems more common with established CBO's – with people in the community implementing their ideas about HIV prevention. He then posed the question, "How

do we dialogue with community about their informal theory?"

Discussion Summary:

❖   A participant from New York City suggested working with the CBO's to back into the formal theory by looking at, from a common sense perspective, what they have identified as the needs of their population. This was said to be useful for seeing connections and creating more explicit and articulated interventions. She said they are currently doing this in New York City.

❖   Charles Collins said that Laura Leviton made the same point in an earlier presentation – that of going in and identifying what the informal theory is to indicate ways of backing into evidence based programs or theory based programs. He asked for more suggestions of ways to open a dialogue that would help honor the CBO's informal theory and yet still start to integrate components of formal behavior change theory.

❖   Another point was raised that they want to be able to understand why something works in the informal/implicit theory and also with the adaptation issue. Why does this work? Why is it appropriate?

❖   A participant from New York City responded to the inquiry saying that one of the places that they start with the informal dialogue is to say, "What benefit is it going to give to the CBO?" She said that often CBO's have to write proposals for grants, and that a lot of the grantors ask for a theory based intervention. They want to help build the capacity of the CBO's to be successful. In New York City, they are approaching it in a couple of ways: being successful in terms of the grant applications and also being successful by demonstrating a difference in the lives of the clients by using a theory and testing a hypothesis that comes from the theory. When they issue RFP's, they find a number of different theories that are HIV related and ask the CBO's to identify in their proposals which theory comes closest to the approach that they're taking in their organizations. Also, they're trying to build in training and technical assistance for the organizations by having presentations in behavioral theory that relates to HIV prevention programs. This includes helping individuals that work with the organization identify one aspect of an intervention for evaluation to talk about what theory that relates to. They are not doing it comprehensively across the board at the moment because it is expensive, but they are doing it incrementally and they do have a vision of where they will be in five years. So, they present certain behavior change theories in the RFA, asking CBO's to identify the closest theory to what they are doing in practice. However, the CBO's can also present some other evidence based approach as an alternative.

❖   A Georgia participant said that they do the exact same thing in Georgia; however, she

said they ask the CBO's to take the theory from the community, write the proposal and then they fund the organization to do a needs assessment based on that. From that needs assessment, they would back into a more scientific based intervention for the particular population they would serve.

❖ An inquiry was made relating to how many health departments ask their contractors/CBO's to make explicit their thoughts and experience through the use of a logic model, and whether this exercise was beneficial for understanding the interventions that the CBO's are proposing.

❖ A participant from Connecticut said that for the past four years they have had The HIV Evaluation Bank. She said they work with their contractors to talk to them about science based interventions and this includes a lot of site based technical assistance and training. She said they started out by using a logic model as a way to back into how to create science driven interventions. She said the department has adopted it as a way to devise a work plan and to help people think about how to design their interventions in science. She said it's been very effective in Connecticut.

❖ Another participant from Connecticut added that she now works for the health department and is in the process of trying to develop an RFP integrating the evaluation guidance and integrating what they've requested from contractors in the past (logic model, separate work plan). She's trying to integrate the steps of the logic model, the steps of the work plan and the requirements of the evaluation guidance into a form that will be user-friendly and not too difficult for CBO's. She explained that the CBO's in Connecticut will have great difficulty putting their proposals together and that if they use things that are evidence based or use citations, she said they would probably be doing it because they think that's what the health department wants – not because they necessarily have confidence that they'll be able to do that intervention. They're trying to provide some capacity building around that because it's difficult. She noted that if she were a program director for a CBO told to replicate a model out of the Compendium, she didn't think she could do it. Realistic experiences have to be taken into account and that is part of the challenge.

❖ A participant from Texas said that they are planning to move in this direction, although they are not doing it now. They are planning to put logic modeling into their RFP for the next funding cycle. They are trying to avoid the words "logic model" and "behavioral theory" but still incorporate those into the RFP. He explained that they want to get people to lay out the risk behaviors and even describe health-promoting behaviors they are trying to produce in their clients. This would be connected to behavioral determinates, which is where the theory comes in, and then go to the next stage of determining what behavior change they are trying to achieve. It's very behavior oriented and he is not sure that their behavioral risk factor data is good enough to support all that

they're trying to do. They've come at this from trying to do outcome monitoring for the last few years and they've found that they can't do it because their programs are either not designed well enough, or they don't know their design well enough, to develop evaluation questions that are specific enough to get any results.

❖ Charles Collins explained that the disconnect for those working at CDC is that in many cases they have to stand by the evidence of something working. They have to err on the side of conservative science. There is a culture at the CDC to favor the first two columns (formal theory/evidence based); however, CBO's across the country do not favor these. He said the dialogue they are reaching for is to learn more about what the CDC struggles with and also to learn what the states struggle with, in terms of making programs more evidence based/science based, but in a way that honors grass-roots creativity and the history of working within the community.

❖ A participant then made an inquiry in reference to the majority who indicated that there had to be some adaptation in order to replicate an intervention. He wondered the extent to which that adaptation has been chronicled, and also who is asking the question around capturing the informal theory, and then backing in. Since CBO's are community driven, and that there is buy-in from the community to evidence based practices, then there needs to be a continual dialogue in the form of a partnership.

❖ A point was made that informal theory, also known as grounded theory because it's on the ground building up, often has elements of formal theory. It's important to make that connection with the CBO's. Most of those in academia often try to bridge theory and application, so it's important to connect with CBO's and have them understand that it's important for them to also teach about application and applying it to theory.

❖ A participant from Connecticut discussed a pilot program in the state of Connecticut. She said that they have been interested in the issue of bridging science to the practice, and they've discovered a disjuncture in the language and communication between scientists and CBO's. They did a pilot run of The Community Evaluation Fellowship, where they asked for volunteer contractors to spend several months with them in an informal setting, which was actually her house. She said they sit around, eat bagels, drink coffee and talk. The only requirement is that they come in with a glimmer of an idea of what they want to evaluate. The scientists in the room are behavioral social scientists from the University of Connecticut and Yale. Their six CBO's have moved from designing science based evaluation plans and they are spending the summer with students from UCONN to help design their instruments and collect their data. They will meet again in the fall to talk about what to do with the data that has been collected and discuss ideas for analyzing and interpreting data for the various constituencies that CBO's serve. She thought it had been a wonderful experience.

❖   Gary Uhl, with PERB, commented that the environment will probably change in the next few years because of the upcoming requirements for CBO's regarding process monitoring and outcome monitoring. He said the guidances for those will be coming out shortly, along with additional technology transfer tools and training. He said CBO's will probably end up being much better versed in terminology and strategies.

Charles Collins
Group Activity

Charles Collins then gave instructions for a group activity, indicating that each participant was given a different colored card to correspond with colors assigned to the four paths (Pink = formal theory; Yellow = replicating science based programs; Green = tailoring evidence based programs to fit local situations; Blue = informal theory). He asked that participants with the same colored cards get together and identify the three major benefits and three major barriers that a health department would have in specifying grantees use the particular theory. The following presentations were made by each group:

Informal Theory (blue):

Pros

❏   It's non-threatening and consistent
❏   It's experience-related – coming out of a community that is using it
❏   It's easily "generalizeable" - replicable and applicable to the communities (people recognize themselves in it)
❏   It's best for encouraging improvement and empowering the CBO (easier to back into formal theory if they can see that what they're doing actually does have a rational basis)

Cons

❏   It hasn't been evaluated.
❏   It can be perceived as non-scientific and de-valued by scientific community/funders.
❏   It will take a lot of money to test it.

Charles Collins reiterated that one con could be that the scientific community could reject the idea, although a pro is that by using this approach the community would be honored. He pointed out that they would get community buy-in and also avoid a power struggle between the state health department and the local community by insisting on other paths. He then said he would like more clarification on why informal theory programs would be more generalizeable.

A group participant said that when the CBO develops the theory they would consider a lot of factors, such as how to reach the clients and how to meet their needs. He said that this kind of

theory is easily adapted by other CBO's because it's the real thing, while formal theory only comes from the top – from scientists that don't know what's going on out in the field.

Replication With no Adaptation (yellow):

Pros

❏ It's already ready to be implemented – no experimentation or processes are necessary
❏ It's easily evaluated – assuming it's implemented as written
❏ The probability for success is high
❏ The TA needs are clear – know what the interventions are and what will be needed as far as assistance to replicate the programs.
❏ It's already been shown to be effective.
❏ It would have standardized interventions across a jurisdiction.

Cons

❏ It might not be tailored to the populations at risk in that jurisdiction
❏ There might not be an intervention or model that has been developed for certain populations
❏ It might not be a good match – the population might have certain cultural nuances that would make it inappropriate.
❏ There is no local ownership – community members were not involved in the process or development so there might be minimal support or a feeling that the grantees are forcing it down their throat
❏ It requires more management to make sure it is being implemented as written
❏ Fewer interventions would get funded

Formal Theory (pink):

Pros

❏ The plans have already been evaluated – no need to come up with new designs
❏ It's concrete – you can see where you're going and what's happening
❏ It's efficient

Cons

❏ It's too generic – not culturally based or socio-economically based so it creates challenges for those populations different from the groups that have been studied
❏ Developing the evaluation is not always possible – some communities don't have the

evaluation capacity necessary for carrying out the plans that have been studied and replicated elsewhere

❏   The top-down model limits possibilities for research/programming and also tends to be RFP driven (name-dropping of others who have done the same evaluation)

Proven Interventions With Adaptation (Green):

Pros

❏   It's already evidence based
❏   It can be tailored to the community to receive community buy in
❏   The structure is there, but it also has flexibility
❏   It has an evaluation component already developed that can be tailored to needs
❏   It's building on an established body of knowledge, but still allows for creativity and inclusion of other formal theory
❏   It's realistic and the most likely to actually happen and work

Cons

❏   There is a risk of losing a key element
❏   Risk of not doing what the original intervention designed – could lose efficacy (fitting square peg into round hole)
❏   There might not be the expertise or trained staff for the translation
❏   There could be a struggle with rigidity ("do this"/ "can't do that")
❏   A lot of "take off the shelf and use it" programs don't fit unless they're being used for the same target population

Discussion Summary:

❖   A question was asked about the translation of all of those plans into the state or jurisdiction application to CDC and how they are going to take the 90 plans and send them to CDC.

❖   Molly Herrmann responded by saying that part of it refers to the population evaluation handout that she discussed and creating a matrix of population by intervention. That is how they will summarize their work for the CDC. They asked agencies to fill one out, even those with 10 or 15 intervention plans, so that they could get an idea of what they were doing, too. Looking at it visually sometimes points out areas where too much emphasis might be placed (heterosexual risk). She explained that they have an intervention plan code assigned to each one that they drop into the population intervention grid.

❖   A question was posed about how the technical assistance aspect would be handled when doing a competitive bid. There was a concern about some organizations receiving more information than others.

❖   Molly Herrmann said that they have struggled with that to some extent. She referred back to two CBO's that currently provide on-going technical assistance to their peers and she said that those organizations would also be applying for funds. She admitted that it's not the best system. If they have an RFP, they have decided to have a bidder's conference telecast, where everything is recorded and everyone has access to questions/answers. They've gone round and round on it because they don't know if they are unbiased themselves. They have not been able to give any information to inquiring agencies, but they would be able to ask questions at the telecast bidders conference.

❖   One participant then mentioned the possibility of developing a coalition of different agencies because he said that one of his regions actually applied as a coalition and received more money as a result.

Concurrent Session Two – Intervention Quality/Scientific Basis

Qairo Ali
Marlene Glassman

Qairo Ali (CDC/PPB) and Marlene Glassman (CDC/PERB) gave the same opening remarks as they did in the morning session. Marlene Glassman then introduced Sandra Klocke and Nancy Jo Hansen, both from Nebraska Health & Human Services.

Sandra Klocke and Nancy Jo Hansen
Health Department Peer
Nebraska Health & Human Services

Sandra Klocke and Nancy Jo Hansen shared information about how Nebraska decided to handle the interventions, in terms of the scientific basis and sufficiency of plan. Ms. Klocke explained that Nebraska has been in the throws of change for the past couple of years with trying to implement the Evaluation Guidance, and also changing the community planning piece. They started by combining Prevention and CARE into one statewide group, which was a change from the previous six regional groups.   The composition of the group is made up of four categories. They did this in order to ensure that they had the kinds of scientific people necessary to make decisions, as well as local/sub-grantee/geographic input. She explained the four categories to be:

❏   *Standing Positions* which include behavioral scientists, Title III's, corrections programs and similar entities from which they need input;

❏   *Elected Positions* which include the sub-grantees, in terms of different types of services (counseling/testing, prevention, CARE);

❏   *Elected Positions* which include those from infected and impacted populations, as well as risk groups;

❏   *Regionally Elected Positions* which include those responsible for determining the priority populations.

Sandra Klocke said this group really started in March of 2000, so they had to work quickly to develop priority populations in preparation for a new funding cycle that started January 1st of 2001. The first step was to determine the priority populations. This entailed bringing the group together and looking at all of the data involved, including the previous year's prevention plan, the epidemiology data, the surveillance program information and local information brought in by regional representatives. They had several questions when trying to determine the priority populations:

❏   Does the epi-profile support the inclusion of this particular population?

❏   Is there population-specific information available to support their inclusion?

❏   Are there scientifically based interventions available to even support working with this population?

❏   Are there current or potential community providers who could implement the interventions with this population?

❏   Should this population be broken down more in order to have more effective results?

Once they were able to answer all of these questions, they reached a consensus on what the priority populations should be. Five priority populations were identified. She explained that from there they moved to one of the new working groups called The Interventions Committee. The Interventions Committee was specifically charged with determining what the interventions for those five priority populations should be. Sandra Klocke then turned the floor over to Nancy Jo Hansen.

Nancy Jo Hansen explained the structure with the health department, and said that each of the working sub-committees has a state liaison. She is the state liaison to the Intervention Committee. Her position with the state program is sub-grant manager, which means she monitors all of the contracts that they give out throughout the state for HIV prevention activities. They first called all of the committee members together, wrote each of the populations they were given on a blackboard and then reviewed what the actual task of the committee was.

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Nancy Jo Hansen then referred to a three-page worksheet that was given out to committee members to take back with them to their communities to do research about what types of interventions they thought would be effective in Nebraska, for those populations that they had been given. They divided the populations among the committee members depending on areas of expertise, etc. The members then went back to their communities and came up with interventions based on what they had seen before or had been involved with. They also went to their regional committee members for input on effective interventions, and then they completed the worksheets and sent them to Nancy Jo Hansen. She made copies of the worksheets and distributed them to the members so everyone would know what was being proposed to the statewide group. She pointed out that they were on a short timeline, which made the first year hectic and provided a learning curve for everyone.

Nancy Jo Hansen then explained that once the interventions were submitted by the committee members, they made up packets and sent them out to everybody in the statewide group – which preceded the next statewide meeting. At that meeting, they had dozens and dozens of different interventions that were very specific – meaning they would only fit maybe one agency in the whole state. They also had generic interventions that could have been adapted to different agencies. She explained that they put all of the interventions up on flip charts around the room, and then the whole statewide group got to chop it all apart and add their own ideas. They then put all of that information into a package and sent that back out to the statewide group. She admitted that it was a very cumbersome process, but it was a process dictated by the needs of the statewide group because they wanted to have input.

At the start of the process, Nancy Jo Hansen said that the directive they gave folks was to make the interventions as specific as possible. She mentioned that in Nebraska over half of the population is in two cities, therefore, she knew there would be interventions that would be appropriate for Lincoln or Omaha that would never work in some of the rural areas. As they went through the process, she realized it was too cumbersome to send back out to the communities telling them those were the interventions they could apply for money for. They ended up taking 25-30 interventions that the committee and the statewide group decided upon and grouped them by type.

She said that the handout illustrated the five priority populations that they were given by the statewide group. Underneath each population, they identified two types of interventions that folks could actually apply for. It went back out once more to the statewide group to receive a final endorsement, and the sample she gave to these participants represented how it actually appeared in the RFA. She explained that the third page of the handout is the cover page that all of the applications had. On the form, applicants were asked to check off which population they were targeting, and which one of the eligible two interventions they were applying for money for. She said that this was a nice tool for her as the applications came in because she could tell that they had to examine and apply only for eligible interventions. This process was used to come up with interventions that have been funded for approximately the past six months.

Sandra Klocke added that part of the screening process was to look at the scientific basis that the interventions were based on. She explained that as the RFA's came in, part of the way the application was built was to look at how they planned to deliver those services and whether the plan was adequate to do what they said they were going to do in terms of the population they wanted to reach. Some of what CDC has asked them to do has been invisible to the sub-grantees because *they* didn't fully understand it, so they couldn't try to make the sub-grantees fully understand it. They chose instead to translate from their end, and the results were good.

Discussion Summary:

❖　　A participant wanted to clarify that the committee determined the evidence or theory based qualifications for the interventions – not the sub-grantees. Nancy Jo Hansen said that was correct. She also said that she brought a few copies of their completed RFA if anyone wanted to look at it. She also developed a "tool kit," which provided handy information for applicants, and she had sample copies of that with her as well.

❖　　There was a question concerning #3 of the Guide to Selecting and Justifying Priority Interventions worksheet. The participant wanted to know what types of information were given in answer to this question. Nancy Jo Hansen clarified that these were not questions actually answered by the applicants. Instead, they considered this as a "think sheet" and guide for committee members.

❖　　A participant mentioned sessions devoted to taxonomy issues and translating local definitions so that they're in sync with the intervention types and risk populations. She said she would like information on how they are handling issues such as women at significant risk, youth at significant risk and teen parent conferences. Nancy Jo Hansen stated that just because they said those interventions could be applied for, not every single one was actually applied for and certain interventions were not funded. As far as youth at significant risk, the RFA includes an entire page that must be filled out on the target population. It includes questions such as: Why is this target population at risk? What is it about this group of people that makes you want to target them for this intervention? She gave an example of a youth program called Survival Skills, in which 90% of the participants are either pregnant or parenting. Those types of issues come out in the application.

❖　　Sandra Klocke said that they will fold into one of those populations, and that it just depends on what the project is. She noted that for a number of women at risk, the groups that they funded this year are primarily heterosexual women who will fall into that population – rather than the mothers at risk. Children are the same in that, if it's more of a general population, the youth at risk will fall into the heterosexual population. If it's definitely aimed at gay youth or MSM behaviors, then it would fall into that population.

They translate that based on the information they are given, and the anticipation of what they're going to meet. Applicants are required to fill out one of the forms as part of the application to identify what populations they think they're going to meet and what numbers of populations.

❖ An inquiry was made as to whether there are any interventions besides those listed. Sandra Klocke responded that the only other way an intervention can get funded is through a "special projects program." They do set aside a certain amount of funds in the budget in order to allow short-term projects to be funded that would give some sub-grantees, CBO's, or other community groups an opportunity to try it out. It's a six-month funding period, and they roll these into each six-month period. These tend to be more public information types of interventions. They did discover that they left out some good public information and media types of things. A lot of good ones came through, although they couldn't fit those into the existing interventions. They are trying to take care of those through the supplemental funding.

❖ A participant requested clarification on question #2 of the Guide to Selecting and Justifying Priority Interventions worksheet. She said she understood it to mean that they are determining, for the sub-contractors, the intervention programs that they would use and then translating that information to the actual interventions that the state would use (such as group level or individual level). Sandra Klocke said that is correct. She also said that the way they collect data now is client based and they are still working on a way to make that more useful. She noted that they have adopted Michigan's event form.

Charles Collins and Dale Stratford
CDC Representatives

Charles Collins and Dale Stratford presented the same introductory information about the four paths of evidence based programs discussed in the morning session. After the four paths were described (e.g., Formal Theory, Replicating Science Based Programs, Tailoring Evidenced Based Programs to Fit Local Situations, and Informal Theory), Charles Collins opened up the session to an interactive dialogue.

Discussion Summary:

❖ David Napp, consultant, added that when people look at informal theory it is has to be a logical logic model. Sometimes, people using boxes and arrows might be making a statement that awareness raising is going to solve the world's problems, and that won't happen. Logic to a logic model is an important part both for health department staff to assess whether that logic model is valid, and for CBO's to recognize that putting their ideas into a logic model format alone is not sufficient because it needs to pass some level of face validity.

❖   Charles Collins said that it is common to see established CBO's using more of the informal theory, or homegrown theory, to implement programs. He then asked, from a state health department perspective, what participants saw most often as far as the distribution among the four paths.

❖   A participant from Arizona said that they see a lot of replication with adaptation. They have tried to borrow things from the Compendium and make them work; however, she explained that most of their CBO's operate on budgets under $50,000 – including the evaluation component. There is so much adaptation, she worries about their ability to replicate anything. Charles Collins concurred that because some CBO's only receive around $50,000, it almost forces the program into that column of replication with adaptation.

❖   A participant from Delaware said that they do a lot of replication with adaptation or a lot of informal theory. However, their next RFP will almost exclusively require formal theory. They decided to do this because their funding is low enough that adapting something starts to be very fuzzy as far as what they are replicating and what they are trying to do. Most of the staff they hire for that amount of money are not Masters or Doctorate prepared people and, therefore, their ability to come up with a completely logical and workable idea is not always there. They are giving a shot to starting with formal theory, and then developing a program from there relative to local knowledge. They they will know in two years how it is going.

❖   A Nebraska participant said that they have limited staff, so they usually don't have an evaluation expert for the CBO's, and sometimes not even for the state health department. She explained that they wear multiple hats and only think about evaluation on certain days when they're not dealing with staffing, monitoring, hiring etc. It seems that the Community Planning Group does this part of it, and she gets confused a lot as far as where elements happen. Nebraska has a good approach in that if the Community Planning Group develops theory based interventions, then they should do this part of it. For the CBO's, those evidence based interventions are then already in the RFA and the CBO's are charged with producing a very detailed service delivery plan that operationalizes that theory based intervention. She said she'd like to hear comments from other participants on this idea of not having CBO's recreate what the Community Planning Group should have done. It seems that the CPG comes up with interventions placed in the plan, and that an intervention would not go in the plan unless it were theory or evidence based.

❖   Charles Collins clarified that there were two main issues (e.g, The role of the CPG in helping to establish what constitutes an evidence based program, and then establishing some kind of standard for CBO's to meet when applying for money).

❖   A participant from Texas said that they try to get their CPG's to be as specific as possible about what they want to see happen in the communities and what specific interventions are expected. They encourage pulling from the Compendium, pulling from other published studies, going with hunches on programs with strong reputations, and thinking about informal theories they want to talk about. This has to be fleshed out in a work plan, and that a lot of the heavy lifting can be done through community planning. They want to have that so the health department can be as accountable as possible to the CPG to know exactly what they want to put money into. Their experience with programs in the FT/RA columns is that there is always continual adaptation and re-calibration that has to go on because the communities are not monolithic, and risk populations/environments/needs change. She said that it is a fusion of RA and IT that goes on in the actual implementation process, which makes it difficult and messy even though they are working from a basis. She would like to see them do more work around supporting communities being able to be more specific in their instruction.

❖   An inquiry was posed as the whether the reference to "communities" meant the CBO's or CPG's. The Texas participant said that it has to be both. She said that they are currently doing some capacity developing with their CPG and their providers because, unless there is a shared language and understanding of what they mean by "reputationally strong" or "ILI," then there is no way that the community will have implemented the things that the CPG saw a need for. The CPG recognizes that there needs to be freedom, flexibility, and allowance for creativity and responsiveness to change. Dallas shows a high prevalence among young, gay men of color and that they really hope to see people say they need to do something, such as empowerment, that gives them a safe space to experiment with being young adults without having to sexualize that. At the same time, they want to give the CPG the freedom to say that they're not sure what the content would be because they don't see anything in the Compendium or published literature, but the feeling is that there needs to be a repeated contact intervention that addresses the following issues of self-esteem. Then they would have a more formed intervention that the CBO could use to make minor adaptations to, while keeping fidelity to the model. On the other hand, there is a lot more development work on the second example for someone to actually develop a curriculum that is responsive and addresses those factors that underlie those behaviors. She said she's looking forward to the messy mix.

❖   Charles Collins said that it sounded as though she is in considerable dialogue with the CBO's about what they're providing. He didn't think she could have answered that question unless she really knew the mix of programs that the CBO's had, and how some were moving from one column to another. He noted that an important aspect is that when they start looking at this issue, they may identify that a program is one place, but as they think about trying something from another intervention, or as they learn the language of behavioral science, they might move to another column. He said that capacity building,

from a health department point of view, means the more they dialogue with CBO's, the more they may move and the sophistication about their program improves. He explained a dilemma that the CDC has in that they are supposed to support conservative science. This means that technically, they should support Formal Theory or Replicating Science Based Programs; however, 95 out of 100 CBO's are using the other paths. CDC has a dilemma about supporting the world of science and honoring the creativity of the community.

❖ Dale Stratford added that one of the things that contributes to reducing the contradictory nature of that is if they have a good rationale for the other categories. If it's well-stated and the rationale is clearly explicated in the applications, then it does help to solve that dilemma, because it provides the logic for the logic model.

❖ A comment was made about many Informal Theory programs not working very well and not achieving optimum results. The participant said that they are much more open to the creative ideas if they are well thought out.

❖ Charles Collins pointed out that people were speaking of the comfort level of their own state health department. Some state health departments feel very comfortable with informal theory and others only feel comfortable with Formal Theory and Replicating Science Based Programs.

❖ A Georgia participant said that before the RFP went out, they hosted training around the state in Formal Theories. They used the California HIV/AIDS Institute to convene three different trainings. She explained that they let prospective CBO's know that the RFP would be coming out soon and that they were requiring certain elements, but were hosting training to prepare them to write better proposals. They set the interventions related to ILI/GLI and the like, but they allowed the CBO's to come up with their own theories of what would work. They told the CBO's that any program they proposed would have to be theory based. In addition to that, they have members on the CPG that also serve as CBO's in the community, although this is not always the case. They didn't want to limit that information just for the state of Georgia, and limit what programs could be out there working, because a lot of the folks on the CPG were not actually out in the community doing that, so training and empowering would give them a more comprehensive opportunity to provide services.

❖ Charles Collins clarified that they did training on Formal Theory so that the providers could interpret some of the homegrown interventions that they were doing in terms of theory to enable them to say, "We are using modeling from social learning theory" because they were using peer educators.

❖   A participant from Delaware shared his concern about creativity being involved. He thought that FT and IT were equally creative, and the way to operationalize FT would be as creative as coming up with an original theory to begin with. The least creative usually are R and RA because it is a desperate attempt, with little to no money, to replicate something that is not possible with that amount of money. He reminded participants not to think of formal theory as a limit on creativity. They've done a lot of Informal Theory in the past. By starting from Formal Theory and encouraging creativity there, maybe in three years they could move back over to informal theory with much more confidence and success.

❖   David Napp commented that one of the logic models that underlies this whole idea is that if they help agencies articulate their interventions with more clarity and more evidence that it will lead to better delivery of interventions, which leads to risk reduction and so forth. He said this is the logic model that underlies all of this discussion. While there is a lot of work to be done with helping agencies work within these categories, it begs another question of, "Do the organizations have the capacity to monitor that they're actually implementing the programs as described?" He said they might be giving people just enough information to be dangerous because they do a very good job describing programs, but that is actually not what is happening. There is a whole second wave of responsibility that comes after this piece.

Charles Collins acknowledged that there is no right way or wrong way to work with these four paths. He then requested that the group reflect on the pros and cons to each of the strategies in order to help health departments think more about the wording of their RFA's, and what they're asking of their CBO's.   The following presentations were made by each group:

Formal Theory (Pink):

Pros

❏   It's a well thought out intervention that is scientifically driven
❏   The operational components are tied to specific outcome measures
❏   The evaluation might be less burdensome because of the scientific links

Cons

❏   It requires a level of training to understand the theory components
❏   It might require more resources to implement
❏   It might require more careful monitoring – people won't necessarily understand what they're doing in terms of the theories

Replication of a Program (Green):

Pros

❏   It provides a "cookbook" or curriculum that makes it a lot easier than developing from scratch

❏   Often the "cookbooks" come with forms provided, such as pre/post test evaluation measures that have already been tested for reliability and validity

❏   It's less expensive because the money doesn't have to be put into development.

❏   There is instant approval from funders, such as the state or CDC

❏   There is an expected outcome against which one can measure how well it was implemented

❏   There is often technical assistance available.

Cons

❏   It's not applicable to all populations – it's specific to the populations for which it was developed

❏   Adaptation to local language/culture/circumstances is necessary

❏   It limits the input and creativity at the local level

❏   There might not be enough money to completely replicate the model – for example, there might not be the staffing level available that was used in the original model

❏   The outcomes might be too predictable – might be directed in a narrow way towards one thing and missing other things that are being accomplished

❏   There is skepticism of the effectiveness of those proven models – government restrictions on what is allowed have restrained evidence based models so the programs might be similarly limited by those constraints

Replication with Adaptation (Yellow):

Pros

❏   The adaptation allows a program to tailor something to the individual needs of a community or population and to add things that might be particular to their environment

❏   Could put together a program for less money than a pure replication - it might be less expensive than pure development because some of the materials/approaches/trainings have already been developed

❏   Because they've got a track record already, these interventions are more acceptable to policy-makers, legislators, city councils and other funders

❏   Because of the adaptation element, these are more attractive to grantees than pure replications would be

<u>*Cons*</u>

❏   It's difficult to monitor adaptations
❏   It's difficult to know what the core or critical elements actually are – it's possible that a core or critical element gets adapted out of fidelity to the original model and, therefore, loses a good deal of the effectiveness
❏   This capacity is extremely difficult to develop and maintain – especially in CBO's or small governmental agencies where there is limited staff and experience

Informal Theory (Blue):

<u>*Pros*</u>

❏   There is an automatic sense of ownership – it's affirming to the agency if their intervention is developed into a theory based model
❏   There is buy-in by the agency and their vision by their clients who it was built upon
❏   The track record with the client community is not lost because the intervention has been tossed out or changed significantly
❏   It mirrors "client centered" approach to counseling in that the intervention starts with where the CBO is – more comfort with the intervention by the agency
❏   It could be ready to go with few changes
❏   That agency could come up with its own best practices, which would be regionally or locally specific
❏   The health department dialogue with the agency on theory is an opportunity for the organization to reflect on assumptions they've been making – positive opportunity for change/improvement

<u>*Cons*</u>

❏   The intervention is evolving – might not be structured, focused, easily replicated or easily monitored
❏   Risk of illogical logic model – might not even know it's illogical. This could be a capacity issue for the agency and/or health department to recognize that it's logical or illogical
❏   Because it's built on experience, risk of falling back into "we've always done it this way, therefore, it works" – could lead to resistance to change
❏   The ability for the health department or agency to respond to the issues that are revealed – "airing dirty laundry" for political or historic reasons – or having to de-fund it when "at least we're doing something"
❏   Risk of political attack because it's not evidence based

Discussion Summary:

❖   Charles Collins said that a take-home message would be that as health departments share in the role of accountability – all four of these are accountable paths for health departments. He also said that through dialogue and working with these, programs do improve.

❖   Dale Stratford commented on how impressed she was with the amount of work and care that everyone has taken to deal with the issues and help lay out their complexity over the past year. She said they've really learned a lot about the kinds of problems they are facing and where assistance is needed.

❖   A participant wondered how far they go to stretch the definition of "scientifically based" or "evidence based" when they do the assessment of the CBO intervention plans. She gave an example of somebody doing peer outreach, thinking they could cite research that says peer outreach is a good thing, and so they check the box that says it's scientifically based.

❖   Charles Collins responded that CDC is sometimes asked to provide technical assistance on some of these issues.   He said a state had a new contract monitor who was supposed to monitor the CBO's, and they said that one of the CBO's had been funded for years for putting condoms in a fishbowl in a gay bar. They'd fill up the bowl on Friday afternoon and go back Saturday to see how many condoms were missing. This had been funded as "outreach" in the past. The new monitor had problems with this. Mr. Collins said that many states are moving toward intervention standards so they can be sure that the interventions are appropriate. He mentioned the checklist for an effective intervention in the back of the Compendium as one approach to dealing with the question.

❖   David Napp commented that he appreciated the specificity of the participant's question because it was a concrete example of whether to score something "yes" or "no." While they might look to CDC to say what "is" or "is not," more might be gained from within the jurisdiction deciding together what the minimum standard is. There is a lot of learning that could come from that dialogue. He noted that the bar could keep moving higher as they move into the future, and that the minimum level for "is" or "is not" (sufficient evidence) might vary from jurisdiction to jurisdiction.

❖   A participant inquired as to the role of HPPG in this process. She wondered if just the health department staff goes through the exercise or if there is a role for HPPG in the process.

❖   Marlene Glassman responded by reading from the *Frequently Asked Questions* document under the heading "Intervention Plan Data" – page #9, question #20. She read from the

page, "If community planning considers scientific evidence and justification when prioritizing interventions, and the health department then funds these interventions, does this meet requirements for scientific evidence and justification for the intervention? Or are grantees expected to submit more information?" She then read from background information about the guidance on prevention community planning, "The guidance states that at a minimum the CPG must provide a clear, concise, logical statement as to why each population and intervention given high priority was chosen." She read the response to the question, "With this in mind, intervention plans that include populations and interventions based on the priority set and the comprehensive HIV Prevention Plan will meet the requirements for evidence or theory basis for the intervention, but this is the very minimum criterion for asserting the evidence or theory basis for the intervention." She said that the community planning process will most likely not go into enough detail to provide evidence for justification for application to the target population and setting and in order to do this, she suggested that they do some of the things discussed in the session (logic models, depictions of program theory, re-writing RFP's to ask applicants to specifically provide certain information). She said that, in terms of the role of the CPG, it's really the health departments' responsibility to submit the data to CDC, but to whatever extent they want to involve HPPG (Chicago term) it would be encouraged.

❖ A participant from Delaware mentioned that the standards that one holds to adopt the theory vary from jurisdiction to jurisdiction, as well as agency to agency. He gave an example of an African-American church finally getting involved and being gung-ho. He said that, at this point, he'd take anything that they said. However, he noted that their initial response is not going to meet these things. He expressed his hope that they have leeway.

❖ Marlene Glassman responded by saying that it is their discretion and their determination to work with an agency on capacity building – that they respect their judgement.

❖ Dale Stratford added that she has heard project officers and folks from PERB say, "Just tell us that and let us know what the situation is." She said the main thing is that CDC wants to know how it is going and how it is progressing.

❖ One participant recommended that they speak with Bob Bongiovanni from Colorado. She said they have different levels of capacity in their organizations, so they have standards that an organization has to meet to receive funding. They provide support for the organizations to go to the next level where they might get additional funding.

Translation Issues/Taxonomy Interventions

Facilitators: Kevin O'Connor, Amee Bhalakia
CDC Representatives: Tim Akers, Ted Duncan
Health Department Peer: Barry Callis, MA
CBO Peer: Susan Davis

The topic of these session was the Guidance intervention taxonomy, and how jurisdictions could use it with their own intervention definitions. The discussion included questions such as: What does a jurisdiction do when it appears that CDC's intervention list overlaps and fails to clearly describe their interventions? How does CDC's taxonomy minimize (or aggrandize) the burden on contractors? Can jurisdictions modify the Guidance taxonomy?

This session was convened twice. The presentations were the same, and are therefore captured only once. Following the formal presentations, the participants were asked to break into smaller groups, and each group was asked to engage in an exercise known as "Consultant for a Day."

Kevin O'Connor
Facilitator

Kevin O'Connor, session facilitator, welcomed those present to the session on Translation Issues/Taxonomy Interventions, explaining that the workshop participants had experience in which other participants could utilize to learn from each other. Kevin O'Connor stressed that the workshop was peer based, and that the CDC was seeking feedback from workshop participants. He also introduced the second facilitator, Amee Bhalakia, and then followed with the agenda outline for the workshop session.

Tim Akers
CDC Representative
CDC's Evaluation Guidance Intervention Taxonomy

Tim Akers spoke on the topic of the CDC's Evaluation Guidance Intervention Taxonomy. He gave a brief overview of the history of the development of the intervention taxonomy indicating that the intervention taxonomy stemmed from work from ORC Macro, extracting pertinent data from applications submitted by practitioners, community based organizations, and health departments and other sources of available literature. All of these inputs were combined into the current intervention taxonomy classifications. In the creation of the existing taxonomy, Mr.

Akers explained that the CDC consolidated the information into eight types of interventions. He emphasized to the participants that the information in the taxonomy was based on a significant amount of information collected from multiple resources.

Tim Akers then drew on the experience of the participants, stating that they already knew and understood the issues covered under the taxonomy. He raised several rhetorical questions that participants faced daily in deciding whether the interventions were the right ones that the participants aimed to implement. He explained that the Intervention Plan set forth the goals, expectations, and implementation procedures for an intervention. For the purposes of the reporting requirements, intervention plans should contain data that describes who is to be served, by whom, and to what extent the prevention service has been supported with evidence and a service plan. Akers explained that the Intervention Plan was intended to define the entire process. The taxonomy was intended to be a plan, but it is also a work in progress.

He explained that extensive work was involved in identifying the various types of interventions in practice. This information was obtained through literature, researchers, and practitioners and also the types of interventions that the workshop participants identified.

In attempting to define an intervention, Akers gave an example from the Year 2000 training sessions on the Guidance Intervention Taxonomy. He reviewed the main elements that the CDC used to identify as the most salient in an effective intervention:

❏ Specifying target populations be it MSM, IDU's, based on race factors, other types or orientation.

❏ Choosing the interventions: Is IVI? Street level? Group Level?

❏ Establishing clear, measurable outcome objectives.

❏ Looking at the process. To look at outcome is definitely one of the end goals. How is this program designed, etc? They are not all starting at the same level.

❏ Assessing characteristics of the implementing organization providing the service (e.g., nature of the organization, number of staff, do they have anything in place, etc.).

❏ Describing the data system. Good policy flows from good data. It doesn't mean anything if there's no way to collect the data.

Ted Duncan
CDC Representative

Ted Duncan discussed how Technical Assistance systems were related to classification. He also mentioned the other two workshops that were available as part of the program meeting that covered technical assistance in more considerable depth. He pointed out that the critical role of Project Officers in assessing technical assistance on the Guidance. He stressed that if participants encountered questions or problems, they should contact their designated Project Officer for consultation. He urged participants to not only place requests through their Project Officer, but he also explained that project officers were trained and encouraged to ask requesters to state the problem in writing, as much as possible. He explained that following a submitted request, the Project Officer then refers to a member of the Science Application Team contact, Charles Collins. As the next step, together, the Project Officer and Charles Collins would set up a conference call to discuss the question. Ted Duncan explained that in most cases, the question was resolved at that level. He said that since the Guidance was distributed, about 95% of all states had made some type of technical assistance request, and that approximately 80% of requests to date were able to be handled and resolved through a phone consultation.

Ted Duncan further reassured participants that alternative resolutions were also available for technical assistance if the request required more in-depth involvement such as site visits or training. He cited that at times, members of the Science Application Team were dispatched to perform site visits. Also, resources at ORC Macro had also performed similar technical assistance duties as well. Depending upon the request and situation, sometimes the request will be referred to another CDC contractor, other health departments, or through the Behavioral Social Science Volunteer Program as necessary to resolve issues related to evaluation. Ted Duncan also identified the Program Evaluation Research Branch as yet another resource available. He recalled that approximately 17% of requests were related directly to interpretation/translation issues. He recognized that the large quantity of interpretation/translation issues was significant, but not a major issue. Ted Duncan expressed positive hope that in the near future, interpretation questions and issues in translating the taxonomy would be identified and addressed earlier in the process.

He then focused on the largest category of questions regarding outcome evaluation, noting that approximately 41% of technical assistance questions were concerning evaluation issues. He recognized that most members of the workshop had various questions regarding evaluation interpretation and issues.

Barry Callis
Health Department Peer
Massachusetts Public Health Department

Barry Callis summarized several translation issues that he, as a Health Department Peer, and workshop participants, have encountered in implementing the Guidance taxonomy.   With regard to pre-guidance risk behavior populations and intervention categories established, Barry Callis explained the history of establishing the risk behavior populations and intervention categories, prior to the Guidance. In 1994, there was a movement to standardize the various activity types in order to capture the data. The result of standardization was the development of a scannable tool that could be used by all in order to create some consistency from over 20 different types of forms.

In terms of the aim for congruence between local definitions and taxonomy, the team created their own definitions and cross referenced their definitions with those in the taxonomy definition. Redefining the taxonomy has been aided by program development, contract management, and reporting tools. Barry Callis explained that as part of the program development, the team held six population based meetings, organized by staff from funded programs in order to get the buy-in. The staff input aided in achieving stakeholder feedback on the accuracy of the definitions.

Barry Callis gave an example of how non-risk behavior populations risk were defined for taxonomy purposes from his own Massachusetts experience. He said that in Massachusetts, three programs exist to service transgender individuals. To understand the risk that non-risk behavior populations experience, there were some inherent behavior risks incurred by non-risk behavior populations who are involved in street work, injections, and substance abuse.

He then reiterated several guiding questions for participants to consider, stating that when there is a challenge with a program, in order to ascertain what types of intervention should be implemented, and to determine who is being served, workshop participants should walk through these key questions about the target, program and implementation plans:

❏   Who is being targeted with intervention?
❏   What are the specific risks for HIV/STD's?
❏   What interventions are being considered?

Barry Callis stressed that in using the taxonomy as a guide, it is important to define the intervention based on the current definition and to be consistent in reporting. He then briefly addressed Intervention Taxonomy Reinforcement, stating that in reinforcing use of the Taxonomy, health departments work closely with vendors to involve them in a cooperative relationship aimed at sharing the overall picture of the evaluation effort by increasing buy-in with participants. In this manner, health departments are working collaboratively with the CDC

to improve effectiveness.

Second, he highlighted the relationship between the local community based organization and the CDC intervention taxonomy. He conceded to participant concerns that the current data form was last revised in 1996 and is up for another revision where it is applicable. He further built on the need for development and/or refinement in data reporting to be consistent with the intervention taxonomy. CDC is about to embark on the task of amending and altering various data fields and intervention types. He also mentioned that data tools and forms available locally should be consistent with taxonomy changes.

Barry Callis discussed the taxonomy's role to assist programs to adopt intervention taxonomy using locally defined terms to describe the intervention. He referred to this type of assistance as "outreach," although he noted that each participant's understanding of outreach varied widely. The role of taxonomy reinforcement was to correct misunderstandings that may result in lack of quality data.

With regard to the clarification of local terms and reporting using the taxonomy, he explained that the revisions were underway on the reporting form for use consistently.

In conclusion, Barry Callis presented the audience with a community building example relating it to the taxonomy. Although community building is not a direct part of the taxonomy, he explained that this activity can still be encoded in the "other" category of the taxonomy. He defined "community building" as it "refers to activities at the community level, not directly involved in the delivery of HIV prevention services, that prepare, enable, or empower the community to support HIV prevention and education." He explained that many of the programs that were funded built in some type of planning features that result in community building. Community building captures the type of work that providers perform to be prevention-ready and receptive. In summary of the community building example, Barry Callis explained how he made his definition of community building fit in the "Other" category of the taxonomy forms.

Amee Bhalakia, Facilitator
Break-out Session: "Consultant for a Day"

Following the presentations, Amee Bhalakia engaged the participants in an exercise titled, "Consultant for a Day." This was a concept that allowed participants to problem solve ways to address the issues they were facing. Two different breakout groups engaged in this exercise. Their input is shown separately in order to have an overview of the similarities/differences of the groups.

She asked them to consider these questions:

❏   What are the benefits to having a taxonomy or classification system for intervention?

❏   What are the issues your jurisdiction has faced in implementing the Guidance taxonomy?
❏   What are the significant issues around implementation?
❏   What solutions, strategies or model programs has your jurisdiction used to resolve these issues?
❏   What types of assistance can CDC provide in utilizing the intervention taxonomy?

Concurrent Session One – Translation Issues/Taxonomy Interventions

Each of the groups reported out their findings to this exercise as follows:

Group 1

Issues

❏   Challenge to contractors to "go out of the box"
❏   Classification of programs into intervention components
❏   Public health agencies especially have challenges targeting populations and moving out of their comfort zones
❏   Challenge working with contractors who try to fit old strategies into CDC categories
❏   Dealing with old language (AKA community-level)

Benefits

❏   Common language
❏   Consistency in service delivery

Issues

❏   Community planning priorities don't always translate into CDC classifications
❏   Programs don't translate into taxonomy
❏   TA is "drive-by" and needs to be more long-term
❏   CDC needs to develop a more intensive TA system to help health department staff with turnover
❏   Suggest a TA "bulletin board" for discussion of issues
❏   Need local TA so it's within reach and consistent

Solutions

❏   VA uses "locus of elocution" in defining intervention types
❏   Encourage agency collaboration
❏   Intervention standards developed and contractors educated
❏   Data collection forms developed

Group 2

Issues

❏ Significant issues around implementation
❏ CBOs don't implement interventions consistently
❏ Lack of common language/common delivery of interventions to clients
❏ Lack of common understanding/language among contractors
❏ How to classify interventions accurately if there are many types of interventions within the main approach to reach a population

Solutions

❏ Starting fresh so that all can have a common understanding of language, definitions of interventions, populations, taxonomy
❏ For TA, expand compendium and help to identify what's been done elsewhere so duplication of efforts can be minimized
❏ Synthesize outcome evaluation instruments and methodologies

Issues

❏ CBOs don't necessarily implement interventions universally
❏ There is no common delivery message that cuts across interventions

Benefits of Universal Language

❏ Catalyst for evaluating CBO/Contractor activities encourages focus on intent (e.g., target population, type of intervention)
❏ Helps with evaluation
❏ Helps with development of a plan

Group 3

Issues

❏ Different benefits with a single intervention versus multiple interventions
❏ Prioritization within programs

Solutions

- ❑   CBOs report monthly on each activity and health department translates
- ❑   Written reports/outcome studies
- ❑   Client level data to capture multiple interventions
- ❑   Check box as part of other interventions/programs

Activities/Strategies/Interventions

- ❑   Understanding the differences/relationships
- ❑   Training for CBOs on interventions and taxonomy
- ❑   Reviewing intervention plan
- ❑   Translation, not program transformation
- ❑   Funding for training and training curriculum from CDC
- ❑   Data collection (outreach, palm pilot). What's being collected?
- ❑   Standards from CDC
- ❑   TA provider needs to be an expert (and local)

Group 4

Issues

- ❑   Lack of fit
- ❑   Categories are inflexible (how to count and account for staff/staff time for apps)
- ❑   Large states are not using taxonomy
- ❑   Lack of skills for CBO to categorize
- ❑   Lack of standardization
- ❑   Lack of training

Benefits

- ❑   Helps everyone speak the same language
- ❑   Accountability
- ❑   Helps providers know what they're doing
- ❑   Minimum standards needed as a marker (perhaps certification would help)
- ❑   Directs services to specific populations

Group 5

Benefits

❑   Taxonomy focuses interventions and it really helps people focus
❑   Gives common language to discuss what is actually happening to interventions

Issues

❑   Concern about changes and how that impacts providers (example: loss of funds)
❑   Generate fear from providers
❑   Internal conflict
❑   Confidentiality issues with data
❑   Programs don't fit with CDC taxonomy
❑   Some interventions are a combination (e.g., ILI and outreach)
❑   Rural areas – everyone does everything and separating activities is a challenge
❑   Rural and urban interventions have differences
❑   Quality of data collection problematic
❑   Staff training

Discussion Summary:

❖   Several participants expressed concern that interventions often take the form of multiple interventions, taking issue that the taxonomy currently is designed for single intervention evaluation.

❖   Additional clarification and a possible solution strategy was given by the participant from Wyoming who explained that in Wyoming's RFA's, they could pick the priority target populations, and if they wanted to do several interventions, they had to do a separate work plan and separate budget to track it. They have grantees track everything by single event, and then make sure they get tracked to the right IVI, etc. They don't prioritize. Instead, they let people do the interventions they want.

❖   It was suggested that in order not to lose the complexity that interventions are multi-faceted, written reports are needed. For example, the impact of lack of social structures for gay men need outcome studies to capture complexity. The issue of reporting is that at the national level, CDC is not capturing the complexity – they are missing the ability to do true preventions in the future. It is important for the federal government to understand that.

❖   It was suggested that if client level data was collected with unique identifiers, the holistic nature could be captured.

❖   A representative from Nevada said that their issue was that the activities, strategies and interventions sometimes blurred.   This could be resolved by training CBO's, getting more expanded definitions, and helping the outreach workers understand why they may start out with a particular intervention but in a few weeks or months, they may move into a different intervention. This somehow must be tracked.   Intervention plans must be reviewed on an on-going basis in order to revise when necessary for various reasons (e.g., interventions are not working, intent was to do one thing and another happens).

❖   A participant suggested that it was about translation issues, not about program transforming issues. Sometimes plans needed reworking because they needed to do what worked with target populations.

❖   A representative from Texas pointed out that it was a good opportunity in the planning cycle for looking at the community plan and have the plan specifically target populations about intervention they think are appropriate and specifying intended outcomes.   Texas is happy when a contractor applies. They'll be working with them through logic modeling, part of RFP process, and pre-contract training, so that contractors can start describing their programs in the same language across the state. Texas is moving away from emphasis of contact of people and more on intended outcome to learn whether they are actually doing what they are intending to do in the program. The ultimate goal is working toward a reduction in HIV.

❖   It was noted that some of the contractors have multiple organizations they have to be accountable to.   They might have funding from state and local jurisdictions that they have to file.   One contractor may be getting funding from two states, so they have to file two reports. It's difficult to determine how to tabulate data and have an ability to use common language when there are so many different report mechanisms and different pieces of information filed under different taxonomies.   Even at the CDC level, if there could be commonality in how different data elements are defined and captured, that could be a beginning.

❖   Concern was expressed that to some extent, states felt as though they were being prevented from talking to one another. Perhaps a listserv could help everyone.

❖   One problem is that at the state level, there are different organization that have to be reported to (e.g., state, county, multi-state, foundations).

❖   Amee Bhalakia pointed out that it seemed like the biggest issue was that it was really hard to single out the intervention and its outcome because there was so much going on with the individual intervention. So, where does one draw the line? When does it become a program? Moreover, multiple funders were asking for different types of data. A common language would not only assist states in reporting to CDC, but also in communicating with one another.

<p style="text-align:center">Concurrent Session Two – Translation Issues/Taxonomy Interventions</p>

Group 1

Benefits

❏   Standardized taxonomy allows for comparing interventions across providers and jurisdictions, and thereby facilitates evaluation
❏   It "equalizes" the contractors in terms of reporting and application process
❏   Can build quality assurance into the intervention definition ("must have the following components . . .")
❏   Community planning and providers gain a greater understanding and common vocabulary

Issues

❏   Too much standardization can lead to erroneous "one-size-fits-all" mentality and shifts burden of customization onto the provider
❏   Some providers may not have the capacity to implement detailed standards
❏   May feel "top-down" and threatening to those trying to come up with creative, local programming

Solutions

❏   Does ILI work better than GLI tailored to the intervention level needed?

➡   Have standards with markers not a standardization

❏   Certify

Group 2

Issue

❏ Lack of fit between evaluation categories and actual programs

Solutions

❏ Training and direct interaction with providers
❏ Funding for incentives to clients (but incentives may not work)
❏ Lower intensity (one or two GLI sessions) may be more viable (though less effective) as long as there is skills building (longer time period for single session)
❏ CDC should broker information exchange
❏ Flexibility – accept interventions

Issue

❏ Match of jurisdiction versus CBO definition
❏ Cross-tabulation
❏ Group-level interventions really outreach
❏ Models (categories) are new to existing interventions/programs
❏ Models (categories) may not match reality/need
❏ Activity is specific, category is not a specific intervention

Benefits

❏ Starts process of standardization
❏ Cross-jurisdiction/cross-agency common language
❏ Directs services to specific populations
❏ Provides language for solicitations/contracts

Group 3

Issue

❏ Definitions are too broad/too narrow

Solutions

❏ Involve CPG to define and reach consensus/develop standards – this helps to clarify and to keep local flavor of activities and intervention (Colorado and Oklahoma Departments

     of Health re-visit this annually)
❏   Involve provider in the writing of standards (+ cultural competence)
❏   Use three different forms ($\rightarrow$ UOS – standard)

Recommendations to CDC

❏   Be there to discuss issues
❏   Set up a website or listserv that is archived to query and read posts to reduce "reinventing the wheel" and to help with TA across the states

Group 4

Issues

❏   For some of the larger states and directly funded cities, the taxonomy process of prioritization is being re-invented and not used
❏   Iowa is tracking over 30 interventions and clearly follows the Guidance
❏   Iowa has learned from other states and has used CBA provider to enhance their interventions
❏   Broadly defining category types is a better description of the taxonomy – rather than the intervention itself; the components of the intervention are a whole make-up of interventions with definitional constraints
❏   Translating CPG efforts into CDC
❏   Categories need to be on a continuum

Group 5

Benefits

❏   Standardization of reporting
❏   Common language
❏   Defines what things are being evaluated
❏   Helps providers define what they are doing
❏   Helps to identify gaps in prevention services
❏   Helps to measure what programs are doing
❏   Increases knowledge of provider skills
❏   Cuts down on work the health department must do to summarize data (this benefits CBO and the health department)

Issues

❏ Provider buy-in
❏ Lack of skills to categorize
❏ Interventions don't always fit cleanly (some interventions have different parts of other interventions)
❏ Implied value of one type of intervention over another
❏ Taxonomy may limit creativity
❏ Once the intervention is created, it has to fit a category
❏ Lack of resources (volunteers are doing implementation/creation/defining the intervention work)
❏ Errors in filling out forms
❏ Duplication of clients: Does outreach versus ILI get counted more than once?
❏ Significant issues around implementation (differing levels of where everyone is)

Solutions

❏ Hire consultants (although funding for this is an issue)
❏ URS data management system
❏ Revise existing data management tools
❏ Use different reporting tools (semi-annual report, work plan revisions at the beginning of each year)

Types of Assistance

❏ Training (like the 2001 HIV Prevention Program Evaluation Meeting)
❏ Site visits
❏ Peer consulting among state health departments

Discussion Summary:

❖ Participants agreed widely that the taxonomy provides standardization, allows for the prioritization of categories and accountability. One participant defined the benefit of the taxonomy in that is allowed different groups to "speak the same language." Another participant from Ohio added that the taxonomy helps to define the work being performed by providers.

❖ A participant from Arkansas agreed that the standards the taxonomy creates are necessary as a general marker, but cautioned that generalized standardization or centralization may hinder activities.

❖ There was substantial consensus among the workshop participants that the taxonomy should set forth minimum standards, yet there should be latitude for programs to be scaled and designed on an individual level.

❖ One issue raised was the lack of fit between the evaluation categories, and the actual service delivered through the intervention. Several participants agreed that the reality of collecting the cross-tabulation data required by the Guidance was difficult to retrieve. Other participants agreed that there is also difficulty in recruiting for interventions, even with incentives.

❖ It was noted that a possible solution might be to emphasize training with direct providers, to work on the incentive structure and to modify the model to a lower intensity, minimizing the number of sessions with one longer session.

❖ Funding by category was another issue raised in discussion about the taxonomy. Several participants concurred that the taxonomy can discourage flexibility in that funding is identified by categories.

❖ A concern was raised that intervention participants could potentially have to fill out multiple forms, if the intervention qualifies under several categories.

❖ One message that came through was that taxonomy is not taxonomy of intervention, but taxonomy of categories. That goes along with work-in-progress notion that might be one of the next steps.

❖ It was suggested that they consider the essential components. What they now have is a taxonomy of categories of interventions.   There is difficulty in tracking between multi-intervention programs.   For example, street outreach for group level intervention. Perhaps they need to look at activities to identify activities typical to each type of intervention in order to start catching some of the variations and to understand the relationship between different types of interventions.

❖ Tim Akers noted that the categories were not merely pulled out of the air. They are working with them very closely in terms of structural, behavioral, biomedical, etc. issues. He stressed that there were many people putting in a lot of effort.

Use of Data/Fostering Buy-In

Facilitators: Tomas Rodriquez, David Napp
CDC Representatives: Carl Hill, Dale Stratford
Health Department Peer: Gary Novotny, MN
CBO Peer: Debra Hickman

These sessions focused on ways jurisdictions can foster buy-in for evaluation activities and use their evaluation data to improve their programs. This interactive session drew on participants' own experiences of challenges and successes in these areas and helped to identify specific steps they could take to improve buy-in and data utility in their jurisdiction.

Concurrent Session One – Use of Data/Fostering Buy-In

David Napp, Facilitator
Practical Applications for Public Health

David Napp acknowledged that there are some ways that the Guidance might be an annoyance, and there are things that could be improved in it. He explained that this session would be focused on solutions and on how to make the Guidance better. He then initiated a discussion about issues regarding getting buy-in to evaluation, pointing out that not only might there not be buy-in in the field, but also that some health departments themselves may not be supportive of data collection as specified by the Guidance. He asked the group to consider and give input to the following questions:

❏   What happens if you or your providers are not sold on the idea of evaluation?
❏   What makes it difficult to get buy-in?

Discussion Summary:

❖   It was noted that capturing only the minimum requirements to get the "check to clear" probably will mean that the data will not be very useful.

❖   A participant from Texas commented that they had begun process evaluation early on so that contractors were involved in the data collection process. Data quality has improved for them with acceptance of the Guidance. At the state level, they can identify providers that are comfortable with the data as well as providers that need help. He also said he

appreciated being able to provide his contractors with specialty reports, such as specific information about populations such as African-American men. Contractors can compare themselves with the rest of the state, and CPGs are seeing the evaluation's effectiveness.

❖ A participant from New Jersey observed that non-acceptance can be at a different level. If state-level bureaucrats do not buy into the idea of evaluation, then the entire process will be made more difficult because there will be problems with trying to purchase the proper hardware and software. Also, program monitors must buy in, as they coordinate the activities with the CBOs. Without their full support, data will not come in on a regular basis. At the agency level, there must be ownership of the data, or else there will be issues with data quality, compliance, and other areas.

❖ It was noted that buy-in starts with the people who are doing interventions. One problem is that many of them only want to do their interventions and do not want to collect data.

❖ A participant from Arizona related a challenge with their CBOs, which is that they are afraid that the data will disagree with what they think is happening, and they do not want to know that. They are also wary of comparing their data with other agencies.

❖ A participant from New Jersey said that a key reason for resistance was a fear from the CBOs that the data would be used against them somehow. There was concern that they might lose funding.

❖ People also have concerns about not having the expertise or the background to collect information, said another audience member.

❖ David Napp observed that in his experience, many agencies conduct evaluation-type activities, but do not call them "evaluation."

❖ A representative from New Mexico indicated that in New Mexico, there is a distrust of government in general. The data that CDC or the state health department wants to gather is not always the data that the local agencies want to gather, specifically in dealing with special populations. Other participants echoed concerns about the Native American population. There are also discrepancies between cases that are reported to the state epidemiologist and cases that CBOs collect, which results from a mistrust of the government.

❖ There is also an administrative problem, said an audience member. The "it's not my job" attitude from field operations pervades, and many agencies do not understand that they cannot be monitored if they do not conduct evaluation.

Gary Novotny
Health Department Peer
Minnesota Department of Health

Gary Novotny shared his experiences with fostering buy-in in Minnesota. He said that fostering buy-in is probably the most important criteria in a successful evaluation project because it is a constant activity. In his state, they look at the process as a continuous cycle (e.g., gathering data, using the data, and feeding the data into fostering more buy-in with existing and new players).

In the early 1990's, Minnesota was completing basic program monitoring reports. There were questions about how the data was being used, from both CBOs and at the state level. Other state agencies were embarking on evaluation projects, so their Division felt that they should conduct some program monitoring. They created an RFP to hire an evaluation consultant, and got two consultants.

Before creating an evaluation plan or tools, the consultants advised working in the field to identify the project players and assess what they needed. Building and continuing rapport was an important first step in the strategic process toward getting buy-in. They next developed evaluation plans individually with agencies, and the agencies began working with the very basic plans and tools. They realized that the process would be marked by trial and error. The state department provided a yearly training on the basics of evaluation research.

His contract managers played an important role in the process, working with individual grantees to understand program results via their data reports. They used the data to assess program progress and to identify any program changes. They developed a "progress record," which summarized their thoughts and observations about the agencies' data and acted as the basis for their feedback to the programs. The cycle is completed because buy-in is beginning, or intact, with the programs. Instead of using the phrase "use of data," they use the phrase "using the evaluation results." Having data is but one part of the process. The data must then be analyzed and considered to be used.

Ultimately, they engage in evaluation because they want to stop the epidemic. The evaluation project is about the clients. In using the evaluation results, Gary Novotny and his staff incorporated the following concepts:

❏   Conceptual use, which involves thinking about the results;

❏   Integrating the results with other program information;

❏   Communicating the results with CBOs, funders, boards of directors, CPG's, other staff at the agency who work in other programs, and others;

❏ Remembering the role of clients, which includes asking them about their satisfaction with the programs offered – one program even brought data back to the clients;

❏ Persuasive use, which uses results to propose more funding from other sources and to convince others of the program's merits, incorporating the accountability aspect of the program; and

❏ Instrumental use, which can help decide whether to continue, change, or improve a program or an intervention.

Dale Stratford
CDC Representative
Ways that CDC Uses the Data Reports

Dale Stratford listed the ways in which CDC uses the data reports from the HIV prevention programs which include:

❏ Accountability to Congress, which is important because it affects funding to CDC;

❏ CDC is committed to using the data both in feedback to the state health departments and in national planning;

❏ Patterns of interventions that are being utilized, whether they are based in research or based in other evidence, such as program experience, are noted. Patterns of promising interventions may lead to more programming emphasis; and

❏ Agencies are collecting more information than the Evaluation Guidance requires, and so CDC is looking at other ways to collect that in-depth, quality information.

Discussion Summary:

❖ Tomas Rodriguez commented on findings in San Francisco regarding young MSMs. Since CDC is as national agency, they were able to see similar problems in other areas in the country and share that information with the local agencies.

❖ A participant commented that at present, there is not enough linkage between the data that is collected for the Evaluation Guidance and the Program Narrative. She advocated for training for CBOs and health departments in how to interpret the data.

❖ David Napp commented that perhaps the forms should be rearranged so that grantees can include a narrative after reporting the numbers for an intervention, which would

encourage them to talk about the data immediately.

❖   Tomas Rodriguez mentioned a PCM program that was only seeing five people a month, but because of cultural issues, there was no way to get more people. Information like that can only be translated in a narrative and illuminates the numbers.

❖   David Napp added another way to use data for intervention plans is that agencies are required to report the number (and demographics) of people that are anticipated to be served, so past experience can inform these projections.

❖   A participant asked what Congress looks for from CDC and the NIH and how the data is given to them. Dale Stratford replied that Congress is mainly interested in how money is being spent, for what kinds of populations and interventions, and how effective the programs are. The funding allocation process is not as simple as following the data, she said, because of special interest groups and other factors.

❖   An audience member wondered whether Congress ever questions why HIV continues to rise, despite the money that is spent on it. Tomas Rodriguez replied that they do, and that he has to go to a meeting to justify the actions of a single program. Data is proving that the epidemic is being stopped in some ways, he said, but proving that is difficult.

❖   A representative from New Jersey described his state's interest in geo-mapping. They have a variety of administrative and epidemiological data within the state health department from a variety of programs and activities. Prevention was an area in which the simple questions, such as where the money is going and what is being achieved, could not be answered, he said. The Evaluation Guidance has forced them to think in that direction and to collect process data. He hopes to use that data to contribute to a comprehensive picture of efforts in the state.

❖   Dale Stratford said that there are excellent examples of innovative uses of data to develop program strategies. In Maryland, for instance, they are using many kinds of data to feed back into the strategizing process. A representative from Maryland described how they are using different kinds of information for site selection for their mobile van for HIV testing and STD treatment. They have a committee of people that are collecting STD data, police sweep and crime data, and other HIV-related data to help make decisions about where and how long to site the van.

❖   A New Jersey representative commented on the perinatal prevention work as an excellent example of how data can work together. They overlap data county-by-county to find infants who are infected with HIV.

❖ A participant commented that for specific activities, combinations of data can be effective; however, for general prevention activities and PCM programs, they cannot show outcomes so specifically. David Napp acknowledged the risk of "knowing just enough to be dangerous."

❖ Another participant pointed out that MSMs, particularly high-risk MSMs, are not organized in a way that they can be reached and screened such as, for instance, pregnant women. Their prevention grantees need to think about that, he said. IDUs have similar problems. Outreach and prevention workers have to work hard to reach these populations, because the "cooperative" people at risk that are being reached by most efforts are not as at-risk at these other, more difficult to organize populations.

David Napp, Facilitator
Group Exercises

David Napp then directed the group to break into smaller groups during which they were to reflect on solutions to the problems that they had listed, as well as other problems that they may have. He encouraged them to name three strategies that they could use in their jurisdictions to combat the difficulties, whether they were new ideas or strategies that have been in place. He suggested that they think of it as designing an intervention to change the norms in their jurisdictions about how evaluation is perceived. Following the breakout sessions, the groups reported on their input to the questions:

Question #1

What are some of the ways to address challenges to getting buy-in to evaluation so that you increase buy-in to evaluation in your jurisdiction?

Discussion Summary:

❖ A participant addressed how to get buy-in from the people who are receiving the intervention. In rural areas in particular, just getting the information from the clients is difficult. Feedback to the client is a way of getting participation at that level. Feedback to the CBO can help as well, especially data that they can use to write grants for more funding or to prove that they are doing what they said they would do.

❖ Another group suggested not using the word "evaluation," because it can make people nervous. One of their members commented that representation on the CPG is dominated by CBOs and contractors, so training at the CPG level can take information back to the agencies.

❖ The translation issue is important, commented a participant from Texas. He has been examining their contract monitoring tools and reinforcing that his agencies are already doing many of the activities required by the Guidance, but they are reorganizing it in different categories. They have built trust in the health department by holding community meetings and discussions. Populations understand that public health is there to stop the epidemic, not for political reasons. Making this goal clear has improved all relationships.

❖ The representative from New Jersey stressed that it is a slow process. If they approach the evaluation work from the perspective of helping to manage programs better, then there will be more buy-in. His department set up regular meetings with CBOs so that they can all talk and trade ideas. He has learned about their needs, and he noticed that they wanted to collect more data than he needed. He also discovered that capacity is a large problem. One agency did not even have an e-mail service; therefore, he has built technical capacity into their grant monitoring process. He has worked slowly to get them comfortable with electronic media.

David Napp agreed that the process is time-consuming, like any intervention, and since the Guidance is already out, there can be pressure on the health departments. The group then pinpointed some common themes in the offered solutions:

❏ Two-way communication between the state health department and the individual CBOs;

❏ The mutual benefits of trust, relationship-building, and credibility of the community and the government;

❏ Reliability of data;

❏ The time that the process takes;

❏ Relying on the fact that people really want to do a better job fighting the epidemic; and

❏ CPGs are asking for more data (and there is an element of mistrust there: re-framing the task to ask for data that will help them rather than for evaluation will help).

Question #2

What are ways to use evaluation data in your jurisdiction?

Discussion Summary:

❖ The first group discussed Texas's approach, which is using process data from their new

prevention counseling form along with the epidemiological profile morbidity data to plan for target populations and priority-setting. They use that information with local needs assessment and other local information to help set priorities. They also use client feedback to help understand risks and help their CPGs understand populations that are being served. They are also generating special reports and getting the information back to contractors so that they can not only see the information, but also see how it is being used and how they can use it better. The contractors see better value in the information if it is theirs.

❖ David Napp asked the group how many people were planning to use or were already using Guidance or other evaluation data to feed into their community planning process. He asked them to list other ways that they are using data in community planning other than to understand risk populations.

❖ A participant replied that it was acting as their resource inventory. CBOs can use the combined reports to get a sense of their area, using that information in their evaluation reports. David Napp commented that in his work in national technical assistance with community planning groups, he focuses on priority-setting, which includes doing a resource inventory and being able to say "who is doing what for whom."

❖ Another participant considered using the data to examine the feasibility of using an intervention for a given target population. If an agency wants to do a certain intervention with a certain population, process data can help them focus their efforts. Numbers of people reached can be particularly helpful.

❖ A participant asked how to use the member surveys and the co-chair surveys, which are part of the Evaluation Guidance. Another participant suggested using that information in the progress report to CDC which has to report on the core objectives of community planning. One of those objectives is to illustrate that the CPG is representative of the population served and has the appropriate expertise. David Napp added that if they see that their membership is lacking, then the recruitment committee can assist.

Question #3

What are other ways that evaluation data can be used?

Discussion Summary:

❖ It was noted that other agencies' reporting requirements can be fulfilled.

❖ In Maine, they do performance-based contracting, which incorporates outcome measures. In their annual report, they combine their demographic information with outcome

information and report it by agency as well as in an aggregate form. Agencies can see how they are doing, and then the data can be used in the renewal process and to raise the bar on their projections.

❖   Contractors that get local funding use state forms to report to those agencies to prove their needs and to ask for more funds and support.

❖   Data collection can be like a mini-assessment within an agency, so if more things are recorded than CDC asks for, such as referrals, then the needs of the clients can be better documented and used to get more funds.

❖   If other agencies have been more successful, then their evaluation results can be used to adopt their approaches.

❖   One state asked their grantees how they were using their data and discovered that the most frequently reported use was for grant-writing. Other ways included internal sharing and reporting, for other external reports for other funders, and for publication. They also used the data to monitor accomplishments of goals internally and to improve or change their programs.

<p style="text-align:center"><i><u>Concurrent Session Two – Use of Data/Fostering Buy-In</u></i></p>

David Napp, Facilitator
Practical Applications for Public Health

David Napp's presentation was the same as that delivered during the morning session, though the discussions and input varied to some extent. As he did with the first group, David Napp asked the participants to consider and give input to two questions. Rather than deliberating the questions, the larger group generated a list of ideas following each question.

What happens if you or your providers are not sold on the idea of evaluation?

❑   Evaluation does not happen;
❑   There is inconsistent participation among and between agencies;
❑   Poor or no evaluation threatens the availability of data;
❑   The quality of data collected is poor;
❑   Without buy-in to evaluation beyond the health department, there is little cooperation, no follow-up, and no one cares about the project; and
❑   If HIV programs are not as well-supported as other programs, then agencies do not want to use their time to gather data for HIV.

What makes it difficult to get buy-in?

❏   Capacity at the local and state levels may not be sufficient to conduct evaluation;
❏   some agencies and programs are threatened by what might occur as a result of the evaluation, such as loss of funding;

❏   Some programs are actually doing evaluation-type activities, but not calling them "evaluation;"

❏   The systems are overloaded;

❏   Past experiences with other agencies lead some programs not to trust that the data will be used appropriately;

❏   In pre-existing relationships with agencies, when feedback has been given, there has been a lack of follow-through;

❏   Programs are trying to establish their identities and differentiate themselves from some of the other agencies that request data;

❏   Inertia and wondering what happens to data at the other end, after it is collected;

❏   Many who run projects work hard and may be overloaded;

❏   There is a fear of change;

❏   Anecdotal experiences make them wonder whether the evaluation is the best use of time and resources and whether it is capturing all of the risks and information that needs to be captured – does the evaluation really reflect what is going on in the program;

❏   Programs think that working with evaluation "experts" is a waste and do not understand that evaluation information will show a real difference between perceptions and what is actually going on, looking deeper into their populations and activities;

❏   Despite doing evaluations for 20 years and giving a lot of agencies funding, there is still much that is unknown about HIV, and there is concern about poor results given the amount of money spent; and

❏   Evaluation might mean the death of a "pet" project.

Discussion Summary:

❖   A participant was unclear about the goal and research question that was answered by the Evaluation Guidance. The form seems only to yield demographic information, she said. Getting buy-in from CBOs and agencies will require a concrete goal. Many people, including evaluators, get discouraged because it is difficult to see the benefits that come from the work.

❖   Dale Stratford agreed with the sentiments expressed. The Evaluation Guidance is a reporting system which, she acknowledged, does not gather much "interesting" data. It primarily helps CDC decipher what money is being spent on what interventions in what populations. Some of the deeper questions about the effects of the interventions go beyond the Evaluation Guidance. The underlying goal is to battle the epidemic, she said, and they have to rely on that goal to encourage all of them to buy into evaluation as a critical way of looking at what they are doing. Fundamentally, the issue is beyond the Guidance, which is a first step to CDC being able to be accountable to their funders in Congress. She said that having *any* data is better than having *no* data.

❖   A participant suggested framing the Guidance requirements as research questions. They are basic and focus on process, but phrasing can make them seem more interesting to foster buy-in. Questions can also ask health departments to reflect on the theory basis for their work, which also encourages ownership of the data.

❖   Another speaker praised the Guidance's focus on using effective, behavioral-based intervention. The Guidance can also be a stepping stone to doing some good outcome evaluation.

Gary Novotny
Health Department Peer
Minnesota Department of Health

Gary Novotny delivered the same presentation which he did in the morning session. Following his talk, the floor was opened for discussion.

Discussion Summary:

❖   A representative from Georgia asked Gary Novotny whether he could use Minnesota data to prove to the state legislature that their work prevents HIV. Gary Novotny replied that they could not, as only one of their programs has any scientific, positive outcome data. Some of their agencies are ready to embark on that level of evaluation, but are waiting. The Georgia representative commented that he had found frustration in not being able to

use the evaluation system to prove that HIV is being prevented. The U.S. is more successful that other countries, he said. Mr. Novotny described a program called "Man to Man" at the University of Minnesota, which is a two-day seminar approach with a pre-test and a post-test. They have been able to demonstrate that if certain issues are addressed, then risk behaviors will decrease. When the state legislature found that the program was targeting homosexuals, there was a furor. The legislature now even has a statute wherein they want to measure the number of sexual partners as part of the evaluation. They think that reducing the number of sexual partners reduces risk.

❖ A participant observed that the epidemic has been studied for a long time, and that there is evidence about what approaches work. When ensuring that interventions are theory-based and connected to practices and behavior change, it is possible to use national information to prove that certain interventions work and are linked to decreasing risk behaviors. Even without specific outcome information for a particular program, process evaluation can show how that program, tied to a theory, can communicate to decision-makers.

❖ David Napp asked the group whether they are closer to being able to say to stakeholders that what they are doing is saving lives than they were before they began to implement the systems. The process is developing nationally, and he posited that being closer to being able to say that lives are being saved is a worthwhile measure of success. Dale Stratford agreed, adding that CDC offers technical assistance on outcome monitoring.

❖ A participant remarked that using research and theory may satisfy stakeholders in the beginning, but they will eventually want real data. David Napp agreed and added that sometimes legislators and other stakeholders might not be informed about how success is measured, so some education is necessary. Sometimes, these groups need to understand that just because rates are increasing, it does not mean that the programs are not working: they can be preventing an even greater increase.

❖ Another participant asked Gary Novotny how they coped with the diversity of needs from their providers as they gathered feedback and input into the process (e.g., How did they reconcile trying to incorporate everyone's needs with trying to have an instrument that was standardized and feasible to execute statewide?). Gary Novotny replied that the grantees did not ask for much more than what CDC required in the Guidance.

❖ Fred McCormick, the evaluation consultant from Minnesota, said that they went into the field to see the state of the art of evaluation efforts and to ascertain the technical assessments that grantees might want from the state. There was a great deal of commonality in the thinking. Gary Novotny commented that more CBOs are being brought on-board because of their perceived connection to the target audience, which brought inexperience. He said that process has been difficult with some of the agencies.

David Napp, Facilitator
Group Exercises

David Napp then directed the group to break into smaller groups during which they were to reflect on solutions to the problems that they had listed, as well as other problems that they may have. He encouraged them to name three strategies that they could use in their jurisdictions to combat the difficulties, whether they were new ideas or strategies that have been in place. He suggested that they think of it as designing an intervention to change the norms in their jurisdictions about how evaluation is perceived. Following the breakout sessions, the groups called out their answers the questions:

Question #1

What are some of the ways to address challenges to getting buy-in to evaluation so that you increase buy-in to evaluation in your jurisdiction?

❖   On the first version of any form that goes out to contractors, write the word "draft" so that they have a chance to offer their input and feedback.

❖   Bring all contractors together to help design the instruments. Idaho used this strategy. The representative from Idaho added that the contractors and service providers had very strong relationships between them already, so they were able to build on that connection. Also, she said there are not many people doing this kind of work in the state, so the providers and contractors relish any opportunity to come together to offer each other peer support. The state then involved the contractors and providers in evaluation design while offering training on evaluation. They contributed the information that they wanted to capture and helped to design the forms. The state also visited each organization to observe how they do business, and from there, helping them build the completion of the forms into their everyday activities.

❖   Give feedback in a timely matter after collecting the data.

❖   Use the response "because CDC says so" as a last resort. Focus instead on the positive reasons for doing evaluation. If CDC is blamed for the evaluation, then the inherent value in the evaluation is not clear. CDC's use of the data is not the only reason to conduct evaluation – the information goes right back into the state.

❖   Have quarterly site visits or meetings to work through the data and to teach vendors how to use data to guide their projects and to improve their projects.

❖ CPG involvement will boost buy-in. It will also show how the data feeds into the planning process and in the continuum from planning to evaluation.

❖ CBOs' fear of losing funding might be overrated: stress to CBO's that evaluation is not to take money away from them, but to give them feedback on how to make their programs more effective.

❖ Fund evaluation above and beyond the cost of interventions so that there is no feeling that resources are being taken from the community's intervention efforts. David Napp added that jurisdictions should understand that the gathered data can lead to applying for sources of more funding.

❖ Find a way to address some CBOs' infrastructure needs, such as personnel, space, and equipment to do evaluation. Reinforce the knowledge that the data collection system can bring to the locality, such as computer skills and Web access.

❖ In the past in some areas, evaluation has been done by hand; when the simple forms and data entry came along, it was a streamlining of the process. In time, the workload is reduced.

❖ Remember that providers are running a business, so they are interested in increasing their level of efficiency.

❖ Keep promises and do not promise things that cannot be delivered. Be realistic about time frames and priorities.

Question #2

What are ways to use evaluation data in your jurisdiction?

❖ Feed data back to the CPG. A Participant from Philadelphia said they took process evaluation data from each intervention and mapped it by ZIP code against AIDS case reporting (there is no HIV reporting in Pennsylvania). The CPG used this information in their planning process. They assessed whether they were reaching areas that needed to be reached. The CPG is in the process of deciding about possible changes. They had discovered that some ZIP codes that had a number of services reported no AIDS cases. The information helps prevent role confusion and keeps CPGs from getting involved unnecessarily.

❖ A representative from Houston said that they have been doing outcome monitoring for three years. Last year, they had enough data to present to the community. The CPG is

using the information in intervention prioritization, prioritizing by effectiveness. They are hoping to produce local data on what types of interventions are more effective. The data has not yet been good enough to help the CPG; however, the process of data collection and analysis has led to conversations and focusing of efforts. Programs are getting more effective.

❖   David Napp said that resource inventory is a requirement of community planning. This activity includes assessing who is doing what for whom, and the process monitoring data provides a great deal of that information.

❖   The Guidance has been useful in providing technical assistance to the CPG in Minnesota as they examine the prioritization process: is has helped to establish a common language.

❖   Inform future planning – hear what the priorities were and what was planned and compare that to what was accomplished.

❖   Use the information to examine the cost-effectiveness of programs.

❖   Louisiana has a database to track their condom distribution. They have been able to geo-code the condoms and geo-code gonorrhea rates. There is proof that gonorrhea rates are lower in areas where a large number of condoms are distributed.

❖   Philadelphia used evaluation data in city council hearings regarding HIV prevention services. They communicated that the efforts are making a difference.

❖   Data on providers as well as the clients is valuable. What is the workload of the counselors, how many counselors are there, and is their work effective? Local providers can use the information to improve their programs and the quality of their staffs.

❖   Document the process and results of establishing community norms to lobby with policy-makers to put out materials that are effective.

❖   Mid-stream changes in programs can be helped. Programs can compare their forecasts to their actual numbers and adjust their programs as needed. This shifts evaluation from being a judgement to being a tool for improvement.

❖   Use of evaluation starts with the questions being asked. Develop evaluation according to how the information will be used.

❖   Part of an intervention plan is projecting the people that will be served. Process monitoring data can help them make their predictions.

❖ The data can also give process monitors a base for their work. Consider what interventions require the focus of outcome evaluation: process monitoring can indicate which interventions are appropriate in the areas of stability and number of people reached.

In conclusion, David Napp summed up the session, thanking the participants for attending. He encouraged them to think of at least one way that they can increase buy-in to the evaluation process. Some members of the group shared their plans, which included:

❏ Using geo-systems
❏ Sharing ideas with other states via a listserv
❏ Releasing another bulletin on evaluation
❏ Exploring further resources.

Building Infrastructure for Evaluation

Facilitators: Wendy Lyons, Jeanette Nu'man
CDC Representatives: Aisha Gilliam, Winifred King, Sam Taveras
Health Department Peer: Frank Laufer, NY
CBO Peer: Prescott Chow

This session addressed the implications of evaluation costs, and the resources (physical, financial, and staff) needed for Guidance activities. Questions addressed included: What does a jurisdiction do if there is only limited past experience within the health department in the area of evaluation? How does a jurisdiction go about contracting with a consultant? What does a jurisdiction do if there are few, or no, staff available for evaluation activities? Are there strategies for locating additional resources, or for implementing the Guidance when resources are limited?

Jeanette Nu'man, Facilitator
MACRO/HIV Prevention Projects

The facilitator, Jeanette Nu'man, welcomed participants and then introduced the CDC representatives and health department peer who conducted the session. Jeanette Nu'man said that the session focus would be to look at the elements of evaluation capacity, and that they would be expanding on the brief discussion that took place the previous morning. She noted that the session was designed to be a "work"shop – meaning participants do the work. Participants would be given the opportunity to examine one critical issue for their jurisdiction/organization and also to develop a strategy to address that issue that relates to evaluation capacity.

Jeanette Nu'man stated that the goal for the end of the session would be to identify critical needs and then identify possible strategies for addressing those needs. She then turned the floor over to Wendy Lyons of CDC, Program Prevention Branch. Wendy Lyons briefly reviewed the components of the information packets given to participants and introduced the next presenter – Aisha Gilliam of CDC.

Aisha Gilliam
CDC Representative
CDC, Program Evaluation & Research Branch

Aisha Gilliam discussed the foundation upon which CDC will be examining evaluation capacity. She said that some of the factors are "motivational forces" which has a lot to do with the philosophy of the organization and the goals to provide effective programs. She explained that some of these motivational forces are:

❑   The policies that pull organizations toward evaluation (overall mission/goals);
❑   The policies that push the need for evaluation within the organization; and
❑   The standards and challenges (internally/externally).

Some of the "pulling" forces could be:

❑   Competition for funds among organizations (health departments, CBO's, universities);
❑   Awareness of benefits – internal needs assessment;
❑   Opportunity to improve overall programs in order to work effectively and efficiently with the populations served.

Some of the "pushing" forces could be:

❑   Grant maker requirements for CBO's and other organizations;
❑   Reporting mandates of funding agencies that are under the gun to provide information to the federal government to determine program effectiveness;
❑   Accountability expectations – organizations are held accountable to funding organizations just as the funding organizations are held accountable to Congress.

Aisha Gilliam described the "organizational environment," which means the properties of the agencies in which evaluation is (or is not) conducted. She listed these examples:

❑   Full-time positions – it's much easier to conduct evaluation with full-time evaluators on board. Those without full-time positions might use consultants or might collaborate with universities or other entities. The capacity is determined by what is being conducted (large-scale evaluation needs more capacity);

❑   Training and professional development – some evaluators have previous training from schools, although on-the-job training is important (workshops, seminars);

❑   Value that the organization places on evaluation. Many organizations are driven in terms of funding and writing proposals, but the information gathered from evaluation could enhance the proposal and justify the need for funds;

❑   Leaders who advocate for evaluation – even though there might be an evaluation team, the leaders have to understand the importance of evaluation;

❑   Use of evaluation findings – to move forward in terms of capacity building and utilization of the results.

Aisha Gilliam then discussed "workforce and professional development." She said that in order to conduct evaluation, there must be knowledge, skills and abilities among those within the environment. CDC would like to establish a foundation that values evaluation, although they know that the professionals within the organization are important as far as carrying out the evaluation. The stakeholders who participate in evaluation should not be forgotten. While they might not be trained in evaluation, they are important assets for providing/facilitating the collection of information and bringing an understanding of the communities for conducting effective evaluations. Stakeholders could also provide entry into the communities.

She explained that resources and supports include locating additional community resources and implementation with limited resources. These are contingent on developing capacity and funding for resources. Technical assistance was also mentioned as an example of resources. She reminded participants that some collaborators (health departments, CBO's, universities) are willing to work with organizations to provide technical assistance (ex. graduate students).

With regard to learning from experience, Aisha Gilliam said that if they evaluate programs and collaborate with others then they would learn from that experience. That experience could teach lessons about the process of using the ability to conduct evaluations (outcome process or research oriented) – being part of an evaluation is a learning process. She explained that finding uses for evaluation could relate to developing capacity, improving programs, answering evaluation questions and being held accountable to the funding agency.

Wendy Lyons, Facilitator
Jeanetta Nu'man, Facilitator
Group Activity

Wendy Lyons then engaged the participants in a group activity, having each participant use a post-it to identify one critical need or issue that they have relating to the elements just discussed in Aisha Gilliam's presentation. Once completed, the facilitators picked up the post-its and attached them to flip charts around the room. The flip charts were titled according the different segments of Aisha Gilliam's presentation.

Jeanetta Nu'man explained that they were going to explore the issues that participants submitted. She said that most seemed to have questions around "workforce and professional development" and "resources and support." She divided the participants into groups according the most pressing issues.

Issues in Each Category (Verbatim from Cards):

Workforce and Professional Development

❏ Building sustainable long-term capacity for CBO's to undertake evaluation activities and for CBO's to get useful results from their evaluations.

❏ Providing guidance to health departments with little or no evaluation infrastructure to gain/develop evaluation infrastructure.

❏ Staff time to do evaluation - with limited staff and no extra funding for evaluation.

❏ How to design programs that allow evaluation to be a part of the design.

❏ How to develop an evaluation component that is effective, but also user-friendly, for local CBO's (easy to understand and not labor-intensive).

❏ The EG requires extensive, cross-tabbed data regarding the clients of our outreach programs. For many programs, this will involve observational and/or sampling techniques that are far beyond the capacity of small providers.

Organizational Environment

❏ I come from a state that has such a strong local public health authority that counties either conduct or contract out interventions (not the state). Achieving buy-in from counties for evaluation is extremely difficult. They see this as an "unfunded" mandate.

Resources and Support

❏   I am the only person currently available to address evaluation (I am the only person in the program – period). What options could I pursue to build capacity from outside sources?

❏   More resources and support to conduct/incorporate outcome evaluations/monitoring.

❏   How to assess our current staff resources and ability to do evaluation along with all of the other things we have to do, such as contracts monitoring, training etc.

❏   Finding and obtaining buy-in from leaders who advocate for doing evaluation and using the findings.

❏   How do health departments ensure that CBO's get the resources and training on evaluation – especially data collection, management, software and hardware? Will CDC provide funding to address this?

❏   Helping CBO's build scientific basis of interventions.

Motivation

❏   Define specific standard.

❏   Knowing the challenges that health departments face in doing evaluations with HIV prevention CBO's.

Jeanette Nu'man then determined the most important issues from the lists and assigned each one a color. Different colored condoms were distributed to participants and they were asked to join a group discussion on the topic matching their color. She told participants that they had the option of choosing another group if they did not want to discuss the topic assigned. Participants were given 30 minutes to begin developing a set of strategies that they could use and were given the following guidelines:

❏   Define the issue
❏   Brainstorm possible strategies
❏   Analyze generated strategies
❏   Finalize a set of viable strategies
❏   Consider how these strategies could be incorporated into a plan of action
❏   Share the plan with the larger group

Participants made the following presentations of their findings:

Group 1

Issue

❏   Conducting services while meeting evaluation reporting requirements

Strategies

❏   Planning to incorporate evaluation activities into programs – requires thinking up-front of wanting the process to be streamlined.

❏   Highlight both the importance and utility of evaluation in order to foster both acceptance and decrease the threat of evaluation (how will it help?).

❏   "Bottom-up" evaluation, which provides a mechanism for evaluation. Some tools would be a logic model, on-site TA, evaluation bank (of knowledge and successful strategies) to increase capacity

❏   Set the stage for evaluation – think it through using the logic model to effectively incorporate evaluation into plans of action

❏   Partnering with other agencies, universities and other entities to help build/maximize capacity – the roles must be clearly defined to avoid confusion on how partnering will work

❏   One participant said that this proposed model is what they currently use in Connecticut. She said she'd be happy to share her knowledge with others if interested

Group 2

Issue

❏   How to assist CBO's in establishing evaluation strategies and implementing on-going evaluation given the capacity/organizational problems that CBO's are facing

Strategies

❏   The presenter said that the strategies focused on the idea that any plans need to be individualized to the agency situation. Each agency is unique and will have a different

set of priorities and needs as far as capacity building. It must be determined whether the evaluation plans are appropriate in scale and resources to the agency needs.

❏   Patience to allow time for assessment - whether approach is appropriate, data collection and infrastructures to support on-going evaluation

❏   Knowing who can provide assistance and TA to providers

❏   Looking at successful turnaround stories – agencies that have pulled out of organizational dysfunction

❏   Establishing training – agency leadership, putting priority on evaluation

❏   Doing a front-end evaluation plan, including the organization's goals/issues – making sure they participate and have their issues integrated into the plan. They would then be monitoring topics of critical interest to them and not feeling as though they are simply producing something to satisfy a funding agency.

❏   The presenter said they did not reach the "plan" stage, although they did discuss that all of this takes time, staff, resources and that it can be highly variable as to the ability to do this intense type of intervention.

Group 3

Issue

❏   Balancing responsibilities of staff with respect to the evaluation function. The presenter said that one area of concentration was the variation in the ability to recruit dedicated health department employed evaluators. They first concentrated on the barriers that need to be overcome in order to accomplish this. Some felt that there was no ability to recruit those staff. They had tried with no success and were pessimistic about being able to get those dedicated resources. Another concern was writing meaningful position descriptions, so that even if you had the resources – could you get the person to do the job? Salary level was another barrier mentioned to recruiting that type of staff with those qualifications. The minimum responsibilities for this type of position would be quality assurance, contract monitoring, training/TA and community planning.

Strategies

❏   The need for health departments and other jurisdictions to share those project descriptions that have been successful in being able to get a person on board (internally) that is qualified to get the job done.

❏   Variation in hiring an external evaluator – universities/health departments/sole-source contractors.

❏   Institutionalizing of evaluation into project monitoring was discussed, although the presenter said the group could not reach a consensus on how to do this. The activities were to integrate them and also to keep them separate. The relationship between "monitoring CBO's" and "evaluating CBO's" seemed unclear.

❏   Institutionalizing training as a long-term investment.

❏   Balancing might be adversely affected by the categorical nature of these programs. He said the group asked questions such as, "Are our requirements similar to Ryan White requirements?" "What about the role of communicable disease programs?" "What about STD partner notification quality assurance activities?" He said the linkage between these activities and where the boundaries are also affects the ability to balance evaluation and integrate it within current roles.

Jeanetta Nu'man pointed out that one of the themes that seemed to be present in all groups was the organizational environment. Two groups talked about the value of evaluation and how evaluation is perceived. Sometimes it's helpful to not look at evaluation as a separate entity, but more from a "learning from experience" perspective. She referred back to a comment about balancing evaluation with other programs and she said that one thing to do is to see them as one entity – not separate activities. If they implement programs, then they have to make value judgments in terms of how the programs are working, if they're working and whom they are serving. She explained that if they see it as part of the program then evaluation might seem less scary. The first step is changing the way people think about evaluation and then other things should fall into place.

Frank Laufer
Health Department Peer
New York State Health Department

Frank Laufer described how New York State has organized itself as far as internal systems support for evaluation and other purposes. It is continuing to evolve and will probably continue to, as the environment requires. He said they have three entities within the Executive Branch of the AIDS Institute (part of the State Department of Health). First is the Administration and Contract Management group, which has developed and maintains a contract management system. This system functions as a centralized compilation of information from their contractors (those that receive state and federal funding through them). He explained this includes demographic information, service information and physical data related to the specific contract(s) that the contractors have. It's collection of prospective information regarding what

the contractors are intending to do as far as a specific program – the demographics of those they will serve and the venues in which they will provide the services. It can provide a snapshot of the contractors' intentions and provides them with some information that they can respond to, such as demographic breakdown of individuals receiving prevention services in a certain area. It is a way to provide information on targets, target services, populations and deliverables.

The Office of Program Evaluation and Research conducts evaluations or assessments of programs to determine the extent to which these particular programs are achieving one or more of their particular objectives. Frank Laufer said this area provides technical assistance to programs, program staff for evaluation planning, assistance with survey development, implementation of surveys and data collection/analysis to include in summary reports. He explained that this office has developed the Community Needs Index, which is a tool that assists with institute program planning and evaluation, as well as policy development – it as a way to provide a measure of need in a particular area at a zip code level. He gave an example of a particular region in upstate New York that could have information put together, such as demographics, program information and other public health indicators that indicate some level of need in a particular area. These areas could be designated as having high, medium or low level need.

The Office of Systems Development oversees their Uniform Reporting System (URS). Frank Laufer explained that the URS is a counter based data collection and relational database tool. He said their contractors provide information that they collect at their program level to the AIDS Institute. The information is provided electronically and is put together into ADA (database of all of the information that the contractors have put together, which reflects client level and aggregate level information regarding services that have been provided by them at various sites).

The Information Services Office is the technology and information center for the AIDS Institute. Frank Laufer said they do ad-hoc analysis and data profiles off of data systems that they have, including ADA, CTS system and the data collection system that preceded URS. He noted that URS is being phased in among the contractors in New York State.

In terms of how New York State got to where it is, Frank Laufer said he has been with the AIDS Institute for less than two years and had to ask around about any other institutional history in order to put together some information around some of the particular factors they had been discussing. The motivation for providing evaluation support was pretty obvious. The funders look for feedback as far as what their dollars are buying, contract management people need to do program reviews, the legislature is always looking for information on how they're spending state dollars and they also have a need to provide some information to the public as far as the epidemic.

He said that as far as the organizational environment is concerned, evaluation is trying to be

user-friendly. It's not trying to be something that peaks over the shoulders of the contractors/contract managers to see what's going on, but something that works cooperatively and supportively with program staff and CBO's to provide some coordinated, comprehensive viewpoints of evaluation for programs. He said that the thought was to make program staff realize the benefits of having evaluation as a tool, and also to help in the allocation of resources – to work with the staff rather than be an adversary. As workforce and professional development is concerned, the institute has been able to build a support system of individuals (researchers, IT professionals) which combine to make the program system something that can offer expertise in evaluation. There has been a commitment to be up-to-date with software/hardware developments and to provide a comprehensive, coordinated and cooperative environment in which to conduct evaluation.

In terms of resources and supports, they've taken monies from state funding, federal funding and other sources and put them together to build up the sphere of evaluation for the AIDS Institute. They provide information on what other individuals have been doing in evaluation to disseminate information. The Office of Program Evaluation and Research regularly publishes bibliographies of what has been going on in health care prevention, as well as a cost effectiveness bibliography.

Frank Laufer said that they also "double-dip" when possible in that evaluation that might be going on for a particular purpose could have more than that one purpose. He gave an example of a pilot syringe access program where the legislature mandated that an outside entity provide evaluation of the program. The department of health was mandated not to do it, but through partnering, is involved in some manner even though it's being done by the New York Academy of Medicine. That the particular evaluation also suffices for what they will do under the Evaluation Guidance. Though he said he hadn't really been around long enough to learn from experience, it is a work in progress that they need to continue to use to see what works and what doesn't in order to make adjustments.

Discussion Summary:

❖   One participant said that, even though he doesn't know exactly what the budget is for evaluation, he knows it's a lot of money and a lot of positions. He asked what message Frank Laufer would have for those wanting to build a meaningful evaluation unit within HIV prevention – how would it be staffed to meet the requirements? He said it would essentially be scaling down the New York experience, but taking the kernels.

❖   Frank Laufer responded by saying that he wished he had a meaningful evaluation unit – he is it. He has extensively used the systems that currently exist. They have the URS, which provides demographic and other information on clients; they have a contract management system that provides information of what the intention of the contractors are (client information). These are the two main tools that he has used to respond to

evaluation, and they are tools that serve several purposes, so there is no need to "reinvent the wheel" to get the information. Given limited resources, a lesson would be to have current systems accommodate certain needs.

Winifred King
CDC Representative
Capacity Building Branch

Winifred King, is a program evaluator on the Science Application Team, part of the Capacity Building Branch at CDC.

In addition to peers, other available resources include NASTAD (peer to peer TA for health departments), MACRO and CDC (provides TA to states through the Science Application Team and the Program Evaluation and Research Branch). Winifred King noted that people should call their project officer to receive TA through the CDC. Once contact with the project officer has been made, someone on the Science and Application Team would be notified, and the issue would be addressed within the Team, or they might collaborate with either PERB or MACRO, depending on the nature of the request. Winifred King explained that some types of TA that could be expected would be:

❏   Interpretation of the Evaluation Guidance
❏   How to ascertain the scientific basis of prevention programs
❏   Process monitoring/evaluation
❏   Outcome monitoring/evaluation
❏   Data collection and management procedures
❏   Strategies to improve quality assurance
❏   Strategies to build evaluation capacity within the jurisdiction

There are some limitations on the types of TA that can be provided:

❏   CDC can not do the evaluation for a health department or analyze data for an individual state (limited resources/staff);

❏   CDC can not come to a state and conduct training on the Evaluation Guidance to a state's CBO contractors. However, they would be providing training to health departments and CBO's in regards to the Evaluation Guidance; and

❏   CDC can not offer more money to build evaluation capacity, although they can provide strategies to build evaluation capacities within jurisdictions.

Aisha Gilliam added that they have five capacity builders who provide technical assistance, prevention design, planning design and evaluation. She said it really focuses on the minority CBO's and she urged participants to inform CBO's targeting minority populations about this assistance.

CBO Evaluation Guidance

Facilitators: Alan Friedlob, Qairo Ali
CDC Representatives: Francisco Sy, Winifred King
Health Department Peer: Madeline Shea
CBO Peer: Claudia Montagne

The focus of this session was the CBO Evaluation Guidance and its direct relationship to the Health Department Evaluation Guidance. Discussions were around how to coordinate CBO evaluation guidance with existing data systems and data collection procedures and other issues brought up by the session participants.

Alan Friedlob, Facilitator
Director of the Citizens Science Committee

Alan Friedlob said that for the past year he has worked as an independent consultant for the Program Evaluation and Research Branch, primarily working on issues related to CBO evaluation and evaluation guidance. He spent about 20 years in public health service, and at his last post he was the Chief of Program Evaluation and Research in the Division of STD Prevention for CDC.   After he left CDC, he worked with the state of Florida in the development of their first HIV evaluation plan. So, he has perspectives – both from the CDC side and also from trying to work with people grappling with some material. He then introduced the Guidance and gave an outline of some of the things that might be useful to participants:

How was this developed?

It was developed over a seven-month period beginning in November with a work group (Carlos, Claudia and Maddy were in the work group). The group met through once-a-week conference calls for about 14 weeks. He pointed out the list of work group members on page 22 of the conference manual, and acknowledged Huey Chen for his initiative and vision for seeing the need for this type of material that could support both reporting and evaluation activities from directly funded CBO's, and also provide additional information that would supplement the implementation of the health department guidance.

What is it?

The work group's charge was to make it consistent with the health department guidance. By using the reporting forms that participants' are familiar with, they have created a manual with a Q&A formatted "how-to" reference to assist CBO's supported under program announcements 99047, 091, 092, 094, 096, 0023, 0100, 0163 with reporting aggregate process monitoring data to CDC on a quarterly basis. It relates to the directly funded CBO's.

How many of these entities exist?

The most recent data that he has gotten from CDC's database is that there are roughly 1550 CBO's in the database, and that about 85% are funded through the pass-through funds. The other 15% are either funded directly through CDC or fall in the dual category of receiving direct and indirect funds. For the 85%, the guidance provides tools and suggestions for methods that will complement their extensive efforts to date. He has learned about the investment that many health departments have already made in implementing the guidance and figuring out ways to make it work with the resources available to the states/local jurisdictions. For those organizations that aren't directly funded, there is information that would be helpful for those efforts.

Specific areas of interest:

❏   In the Discussion of Intervention Plans, they emphasize the use of informal theory or the logic model as the principle means of providing information on intervention plans. This is coming from the work group – from a discussion about the classification of behavioral science and critical examination of the health department guidance. A consensus was reached on the use of logic models being meaningful for program evaluation, program monitoring and dialogue between project officers at the state/federal level.

❏   Measurement of Resource Allocation across intervention types – how to approach that in a non-profit setting. The forms have a section for "expenditures by intervention type" and that they suggest an approach for how CBO's would make that allocation.

❏   Provide for each of the eight intervention categories is a "gold standard" for client level data collection forms. They examined over 100 different forms from different organizations, and they provide the forms as a suggested standard to compare the data collection forms that their contractors and CBO's are currently using – as a method of dialogue, not a prescriptive method. Person-level data ultimately drives this and they are interested in people receiving services.

❏   They provide detailed approaches to measuring the audience for health communications interventions – based on media industry standards. He gave an example from the guidance, "Provide an estimate of 150,000 people exposed to this measure." Francisco Sy said that if the CBO is heavily invested in using media, where media is the core of their intervention and dollars are flowing to that intervention, it is reasonable to use industry standards to measure audiences more specifically. Though it might be "overkill" they would find ways to do that.

❏   Detailed clarification of the taxonomy for community level interventions are included (e.g., examples of community mobilization, structural adjustments and social marketing). There are also appendices that provide user-friendly definitions of behavioral research theories applying to HIV prevention, and questions to ask when conducting a process monitoring process evaluation of community collaboration. They provide a series of questions that could be used to monitor the process of community collaborations.

Alan Friedlob then stated that the desired outcome for the session is that participants would have a hands-on review of parts of the guidance because each group would break down the guidance and review it. He also said he wanted to hear thoughts from participants based on their experience with the health department guidance and on effective ways to extend training to CBO's - for example, measuring the actual expenditures related to the services provided.

Discussion Summary:

❖   Regarding multiple session GLI's, PCM and ILI, where clients are seen for multiple times, a question was raised regarding what to do if participation in an intervention straddles more than one reporting quarter. When should the CBO report it? Alan Friedlob responded that this stems back to using an encounter data form, which CDC has not required. States vary in how they use an encounter level form and whether they use personal level identifiers for ILI, GLI and PCM. He said since CDC hasn't required it, the ability to report that way ultimately goes back to the foundation – individual client level data.

❖   Regarding an agency funded by both the state health department and directly funded by CDC, an inquiry was posed as to how they will ensure that interventions are not being "double-counted" (reported both to state health and CDC). Alan Friedlob said when he put the manual together, he caught some of the issues, such as expenditures incurred in certain quarters. He said these types of nuance questions are very important because they will affect the quality of the data. The CBO guidance focuses on aggregating CBO performance by program announcement – an identification that those intervention activities are associated with a particular program announcement. This will allow them to be carved out from that dual funding stream.

❖ A question was raised about why they did not just develop one general guidance for the health departments and CBO's that guide planning, monitoring and evaluation of programs at the local levels. Alan Friedlob this was the type of policy question that an organization such as NASTAD could address with CDC, but that it was inappropriate for them to give a response to it since they are the analysts who implement that policy.

Francisco Sy, CDC Representative
CDC, Program Evaluation Research Branch

Francisco Sy gave a brief overview of the CBO guidance. He said that one year previously, he was on the other side of the fence when he worked with the University of South Carolina, the South Carolina Health Department and various CBO's in the state. Now that he is on the other side, he realizes all of the work that must be coordinated with participants – one of which is the CBO Guidance. He made the following points:

Why do we need program evaluation?

❏ Accountability
❏ Program improvement for CBO's

Two general types of program evaluation:

❏ Process monitoring that would lead to process evaluation ("How is the prevention program implemented?").

❏ Outcome monitoring that would progress to outcome evaluation ("Does the program reduce clients' risk behavior?").

CBO's funded under program announcement:

❏ 0023 – use approximately three to five percent of funding for program evaluation and outcome monitoring of intervention activities.

❏ 00100 – use approximately five percent of funding for training, quality assurance, program monitoring and evaluation.

CBO evaluation guidance:

Volume 1:   *Evaluating intervention plans and implementation process in CBO's.*

     ❏   *Unit 1* is titled *Evaluating Intervention Plans and Implementation Process*

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Guidance. It's purpose is to provide CBO's with a format and guidance for collecting and reporting process data. The content is identical to chapters 3 & 4 of the Health Department Guidance. It was developed with the health department, CBO's and consultants, and it's been pilot-tested in seven states. It's status is that it was to be submitted to OMB for clearance several months ago, and will probably be approved in July of 2001. Drafts were distributed to CBO grantees in December of 2000.

❏   *Unit 2* is a *How-to Manual*, and it's purpose is to provide additional information and instruments for CBO's to collect and use the process monitoring data. The content was developed by a work group of eight CBO representatives, four health department representatives, four CBA representatives and CDC staff, using weekly conference calls. The status is that drafts are now available for feedback.

Volume 2:   *Outcome monitoring (work in progress)*

❏   *Unit 1* is Outcome Monitoring Guidance, and it's purpose is to provide CBO's with a format and guidance in assessing the effectiveness of their efforts. It contains outcome indicators and outcome monitoring forms developed jointly with CBO's. The status is that the draft is under review by CDC.

❏   *Unit 2* is a How-to Manual, and it's purpose is to provide additional information and instruments for CBO's to collect and use outcome monitoring data. The content was developed jointly with CBO's, and the status is that a draft manual is ready for pilot testing.

Francisco Sy agreed with what Alan Friedlob said about making sure that it is consistent with the health department guidance. The only new addition is a piece on outcome monitoring and that the rest of the foundation was laid by the health department guidance.

Discussion Summary:

❖   An inquiry was posed as to how (CBA) providers will be integrated in supporting CBO's with TA for the guidance. Francisco Sy said that (CBA) providers will be funded and sub-contracted in the future to help with regional training for the CBO Guidance.

❖   An inquiry was posed as to what the outcome monitoring volume includes (e.g., tools, recommendations for implementation). Francisco Sy said that they are in an early draft phase for the outcome monitoring form. They are looking at such outcome indicators as condom use and decreasing number of sexual partners.

❖   A participant inquired as to how the health department will be involved in training/data collection by directly funded CBO's (gap analysis). Francisco Sy said there would be four prevention centers involved with this – the four CBA providers, CDC, SATeam and eventually the health department.

Winifred King
CDC Representative
Group Activity

Winifred King described the purpose of the group activity which was to have the participants become "experts" in at least one aspect of the guidance, and to receive a thorough overview of the other sections at once. The participants were asked to:

❏   Review the section assigned to their group and become "experts" on that section;
❏   Discuss the major highlights of the section and the usefulness of collecting these data; and
❏   Put a report together to present to the entire group.

The group presentations are as follows.

Group 1 - Intervention Plans:

Highlights

❏   Provides definition of intervention plans.

❏   Includes information needed to complete intervention plans – concrete listing.

❏   Assists with how to estimate your activities (staffing, external challenges, past performance, data from other CBO's).

❏   Provides description of science and the need to have it theory based. Appendix includes descriptions of various behavioral theories. *Should also list the justification for population and setting (will be updated for next draft).

❏   Provides information on how to develop a logic model that links activities and outcomes.

❏   Includes web addresses for finding out about the construction of a logic model.

❏   The group agreed that they were glad not to be overwhelmed with excessive information.

Usefulness

❏   Intervention plans provide realistic direction to CBO's.

❏   They provide a focus for the CBO's and health departments to measure progress against.

❏   They validate the programs by linking them to theory (instead of just doing what's always been done).

❏   They give long-term ability to project services and activities – which will lead to an increased ability to attract funding from other sources.

❏   They help to measure program effectiveness and possible need for modifications.

TA Needs

❏   Huge need for TA for CBO's to do intervention plans. The need is especially great up front – with planning to do interventions.

❏   Need for training on behavioral science behind interventions.

❏   Continued training on collecting information/data and collection tools.

Group 2 – Process Monitoring

Highlights

❏   Great definitions – the common sets of definitions to getting the core data is essential.

Usefulness

❏   Pages 14-15 give reasons why this is a good idea – to share with CBO's.

TA Needs

❏   Asking clients about demographic data, as opposed to guessing what it is, is a challenge for some. Some outreach workers/group level guess at the demographics based on surnames or looks. Getting CBO's to ask the question – and not assume – will have to be emphasized.

❏   More and more individuals have multiple risks – how to pick just one? Would data be lost in picking the one risk? Emerging needs information could be lost.

❏   One page summary on volunteers is great for CDC, but not for CBO's (they would not be able to fill out the form). A challenge is giving them a breakdown of what number goes in that hole – similar to IRS worksheets. Different volunteers give different types of services to CBO's. Dollar amounts are hard to determine without breaking it out.

❏   Summary budget sheet is a good idea if you break out where the numbers come from. CBO's need step by step help – it's overwhelming.

❏   A comment was made that the CDC is not looking for numbers of volunteers on the forms, but volunteer hours.

Group 3/6 – Individual and Group Level Interventions

(Groups 3 and 6 were combined).

Highlights

❏   Compared to the health department manual, the way that ILI and GLI elements are defined is much better.

❏   Very clear in the components for GLI that there must be a skills teaching component.

❏   Directions on reporting HCPI were very clear – better than HD guidance.

❏   Ultimate reporting forms are the same – can do comparisons/gap analysis.

❏   Tracking from using unique identifiers to track people across ILI and GLI was much clearer than the HD guidance.

Usefulness

❏   Since the forms are the same, can do gap analysis.

❏   Easier to identify a set of needs via referrals and can also begin to discover a lack of services.

❏ CBO can see that it's okay that they can't do everything – they can reflect on capacity.

TA Needs

❏ Divergence between the definition of PCM for ILI and actual PCM (pg. 29 compared to pg. 38).

❏ Reporting of data from GLI, ILI and PCM when it straddles a reporting quarter.

❏ Might need TA on how to approach state health departments.

❏ TA on program design to coincide with evaluation guidance.

❏ CBO training on how to use and implement guidance.

❏ Training on how to set up data management systems to track ILI and GLI more effectively.

Group 4 – Prevention Case Management Interventions

Highlights

❏ Highlights the six key elements of PCM (risk assessment, developing a client center plan, doing referrals).

❏ States that typically this is prioritized for persons living with HIV, although could also be for high-risk negatives.

❏ Highlights actively disclosing HIV status as part of reporting mechanism.

❏ Highlights talking to people about their partners but doesn't talk about linkages to PCRS.

❏ Talks about what can be counted as a client served – but doesn't address whether locating = serving.

❏ Says that the service can be done in person, electronically or in writing – would urge the reconsideration of PCM in writing.

❏ Supplemental forms do not include data relating to all six PCM elements (backup forms don't meet all of the purposes needed for aggregate form).

Usefulness

❏   Addresses if clients match targets.

❏   Addresses a multi-level approach to risk assessment.

❏   Includes client background information (living situation, living conditions).

❏   Ties into Ryan White – shows accountability, but complicates cost determination for personnel (which part is devoted to care and which part to prevention?).

TA Needs

Need to have the following skills:

❏   Needs assessment
❏   Resource inventory
❏   Gap analysis
❏   Risk assessment
❏   How to develop client center plans for risk reduction
❏   How to identify/develop appropriate ways to work with clients around PCM (protecting them and their partners).
❏   How to conduct a PCM session
❏   Cultural sensitivity/appropriateness
❏   How to make appropriate referrals to follow up

Groups 5/6

Group 5 was eliminated. Groups 3 and 6 combined in Individual and Group Level Interventions.

Group 7 – Street and Community Outreach Interventions

❏   This group first looked at definitions focusing on active and face-to-face educational interventions – approaching people in public places and venues (streets, parks, homeless shelters, drop-in centers, bathhouses and public sex environments). Active street outreach vs. venue based outreach (bathhouses, gyms etc.).

❏   What is HIV prevention and what isn't? The presenter said that a CBO going to a gay bar or other venue and dropping off promotional materials or condoms with someone else passing them out – that is not considered outreach. True outreach intervention is where the CBO's actual staff passes out the materials or condoms.

❏   How do you define HIV prevention materials? Some examples given were: condoms, safer sex kits, promotional items, safer injection kits, brochures and materials.

❏   How should you collect outreach data?

❏   What types of data are collected?

Usefulness

❏   Relative cost of outreach would make it potentially useful – less expensive than other possible interventions.

❏   Realistic approach to prevention.

❏   Outreach workers have face-to-face contact with those out in the community – can determine what is really going on.

❏   Neediest clients might not necessarily be seen in other HIV prevention venues (might be embarrassed – married, injection drug users only worried about getting next score).

❏   Immediacy – the prevention activity comes to these clients, rather than them having to go someplace for it.

❏   It's a measurement of program effectiveness and an accepted approach – CBO's typically have experience with outreach.

TA Needs

❏   How to standardize definitions that are used and how the outreach workers approach/interact with clients.
❏   How to measure effectiveness.
❏   How to collect/report data.
❏   How to train and supervise staff.
❏   How to coordinate with other programs (STD, CARE) – coordination leads to increased effectiveness.

Group 8 – Health Communication & Public Information/Community Level Interventions

Highlights

❏   This group had high praise for the document and that they are excited about it.
❏   Definitions of terms and provisions of examples.
❏   Q&A format is realistic (easy questions to more complex questions).
❏   It's broken down into specific interventions.
❏   It's straightforward and easy to read.

Usefulness

❏   Will help define where the intervention is going.
❏   Will help the health department define even more the direction of the evaluation.

TA Needs

❏   Look at the data forms and examples to see how they are linked and to help the
         department and CBO's use the forms.

❏   Gap: Community level interventions are better defined in the CBO guidance than in the
         evaluation guidance, Volume 1. Can that be equalized?

Outcome Evaluation/Outcome Monitoring

Facilitators: David Cotton, Jeanine Ambrosio
CDC Representatives: Charles Collins, Gary Uhl
Health Department Peers: Roger Myrick, CA and Marcia Sass, NJ
CBO Peer: Maija Neville

The focus of these sessions was outcome evaluation and monitoring. The group will discuss
what a jurisdiction can do if they do not have adequate baseline data for doing outcome
evaluation, and if it is possible to use a time series design instead of using a control/comparison
group. The group also discussed TA needs, including designing outcome evaluations,
identifying evaluable interventions, creating appropriate outcome measures, selecting control or
comparison groups, monitoring data quality, conducting interim and final data analysis,
interpreting results, and understanding the distinction between OE and OM.

This session was convened twice. For the most part, the presentations and exercises were the same, so they have not been captured twice. The discussion/input summaries from the participants, however, are documented separately for each day in order to reflect the similarities and differences in each group.

Charles Collins
CDC Representative
Opening Remarks

Charles Collins called the session to order indicating that there would be a change given that about 48 hours earlier they'd been involved in IRB issues surrounding monitoring and evaluation. They are being told that quasi-experimental designs and experimental designs may be deemed inappropriate for use of cooperative agreement funds because these designs fall into the area of research rather than evaluation. Therefore, a decision was made to hold back on the originally scheduled agenda and have Marlene Glassman field a discussion session. While they don't have a lot of answers, CDC thought that by knowing the questions, they could work on formulating those answers so they can give participants guidance on these issues.

Marlene Glassman
CDC Representative

Marlene Glassman referred the participants to a draft letter in their packets which they included to lay out the issues. She stressed that the letters were drafts pending the approval of the CDC Procurement and Grants Office (PGO) that has jurisdiction over the use of funding. She reviewed the information in the drafts, and then fielded the discussion.

Discussion Summary:

Morning Session

❏   An inquiry was posed as to how CDC planned to deal with recommendations. Marlene Glassman indicated that they would review recommendations/questions posed during the meeting once they returned to their offices. In addition, they will probably create a written instrument to find out what everyone is doing. She pointed out that most of them to whom she had spoken were really engaged in outcome monitoring, which is fine. She stressed that they would have the opportunity to talk about this on a case-by-case basis.

❏   An inquiry was posed about when the Chapter 7 revisions would be out, and what the IRB issues meant in terms of the upcoming applications with regard to submitting their outcome evaluations. Marlene Glassman responded that Chapter 7 would be revised as soon as this issue was resolved, hopefully within a month. If it turns out that the

outcome evaluation is out, then they will have a "meeting of the minds" about outcome monitoring. Then they can write about their plans for that.

❑   An inquiry was posed as to what the key issue was. Marlene Glassman responded that it was research design.

❑   A participant noted that some of them had gotten IRB approval for what they thought they were doing in the way of outcome monitoring because they're collecting confidential data on a pre-post basis from clients. Marlene Glassman clarified that it was not clear when local IRBs would come into play, but she encouraged participants to go through their local IRBs to ensure that they are following appropriate procedures.

❑   An inquiry was posed as to whether there was any contemplation of changing the timeline (e.g., the evaluation is due at the end of the Cooperative Agreement in 2003) in light of this development. Marlene Glassman responded that they could not shift it under the current cooperative agreement because that is getting toward the end. If there is a delay, and it turns out to be just a delay of 4 weeks or so, they probably would not consider extension. However, if there is a delay longer than that, then they will reconsider.

❑   A participant suggested that CDC check with each grantee regarding whether they have multiple project assurances or federal wide assurance, because issues with multiple project assurances can cause extreme delays.

Afternoon Session

❑   One participant wondered how long it was going to take to find out the outcome of this situation. If it's not going to take a long time, he would be inclined not to go back and even tell anybody that things have stopped because it takes so long to get things through his own process. Marlene Glassman responded that she didn't think it would be more than 2 to 4 weeks to reach resolution. She noted that they had one determination already, and she explained the position of the PGO office to this group as well.

❑   An inquiry was posed as to what would happen if a group was in the middle of an outcome, quasi-experimental evaluation. Marlene Glassman said that if they had local IRB which made a determination between whether it was formative evaluation or research, this could help answer the question. She referred to the draft which instructs those with programs in progress not to continue to enroll clients until a decision is made. She said that they all shared the same concerns – that ultimately someone might not get needed services due to lack of ability to carry out interventions. So, they're working as diligently as possible to resolve the situation. She stressed that groups which were not already in the middle of an evaluation should hold off on starting one until a decision was

reached. She suggested that anyone doing experimental or quasi-experimental designs should stop enrolling clients. If it's going to be an enormous problem, she suggested that they call their Project Officer for one-on-one counseling about what to do.

❑   An inquiry was posed as to whether they could just stop the comparison group but continue with the work for the treatment group, because that would be the definition of outcome monitoring.   Some expressed concern that if they stopped the comparison group, they'd then be told in a month or two that it would be okay to go ahead. Then they will have cut off many people who could have potentially provided valuable information to the outcome of the intervention. Charles Collins responded that the Grants Office has the ability to interpret the Cooperative Agreements. At the same time, the Human Research Office is telling them the IRB part, saying they have to shut down any kind of experimental work done by the states with these moneys. Simultaneously, the Administration is saying that all of this went through CDC clearance already. Marlene Glassman stressed that for those who were underway and who had contracts, they will *try* to help seek other types of funding streams so that the work won't be interrupted.

David Cotton, Facilitator
Overview of the Evaluation Pyramid

David Cotton gave an overview of some of the underlying principles around the relationships between evaluation activities.   Referring to the diagram of the pyramid, he explained that it reflected the relationship between the different activities that go on between Community Planning, Funding,Services/Interventions, Implementing Programs, and the expected relationship with changes in risk determinants and changes in HIV transmission.

He explained the basic logic, stressing that it was not quite as linear as the diagram made it out to be, but in terms of CDC funding, the underlying logic suggests that there is a planning process in which priorities are determined – both for priority populations and for intervention strategies for most effective services to help prevent HIV. Based on that comprehensive plan of priorities, that should lead to an application to CDC for funding which corresponds to those priorities. Hopefully, there will be interventions designed that address what's asked for in the application, that funds are allocated, and those things are implemented (hopefully well and with integrity to the original design). If so, it should lead to changes in risk determinants and ultimately in HIV transmission – or at least a cumulative effect of all of those things in a particular jurisdiction.

The Guidance was designed around this logic and has evaluation components that correspond to each of these activities that are parts of the planning, implementation, and results cycle.

One of the ways to think about this is that these different activities also create a foundation on which to build evidence to support programs. The bottom of the foundation is really around the

prevention priorities in the case of HIV in that if the priority setting process goes well and is agreed upon in the community, there should be priorities which serve as a foundation for a combination of both science and community input for both the population to be served and the priorities. Intervention plans would then build on those priorities. If a jurisdiction does not have good interventions which match the priorities, they've essentially lost a layer in their foundation. Similarly, if they have interventions that are well designed but they're not implemented as intended, then there is another place where a break in the chain might occur.

This is another reason that process monitoring is strongly emphasized throughout this process, because there is a critical assumption being made in any kind of intervention work that they're *actually* implementing the thing that they *think* they are. There may be many good designs and a million reasons it's not actually put into the field the same way that the designers believe that it should be working. An intervention that is not mature in that respect, also may not have the expected results. This brings up the issue of outcomes. The underlying assumption in looking at outcomes is that all of these pieces are in place in a relatively complete way.

Outcome monitoring does not answer the question of attribution. Outcome monitoring, as it's used in the Guidance, is really only looking at simple pre/post measures of certain outcomes that are the objectives of the intervention. That kind of measurement will not tell them that any changes that they do see can be attributed to that intervention. It only says that for some reason, things are moving in the right direction. What outcome monitoring does provide is a warning flag if the expected changes are not being seen. It's really an early warning system that design and plans need to be revisited.

Outcome evaluation, on the other hand, puts into play design characteristics that allow a program to rule out other sources of possible influence on the relationship between the intervention and the outcomes being seen. Outcome monitoring is very important in that it provides an early warning system, and David Cotton said he personally believed that all programs should have a provision for outcome monitoring in place because they ultimately wanted to have some initial indication about whether the hypothesized outcomes are being achieved. Outcome evaluation is a more rigorous process, it's more resource intensive, and there are advantages to doing outcome evaluation with selected interventions as well. That is why outcome evaluation is in the guidance, because it's important to build more capacity and more critical mass in that area across the country.

He said the message CDC wants to stress has to do with the relationship of outcome monitoring and outcome evaluation – the building block aspect, and they want to continue to point out the importance of knowing that a program has something well designed, and that it's actually being done the way in which a program thinks it is being done. Those are critical and necessary precursors to asking the questions about outcome. This is important to think about as people continue to consider which interventions may be appropriate for thinking about outcomes. Is it mature? Is it being implemented as designed? Is that likely to be the case throughout the period

of data collection?

Discussion Summary:

Morning Session

❏   If there is a determination that they cannot do outcome evaluation, an inquiry was posed as to whether they could use private funds to do so, and CDC funding to conduct outcome monitoring.

❏   Mr. Collins responded that it would seem that this would still not be appropriate, but he assured the participants that they would check on it and get back to them.

Afternoon Session

❏   No questions were posed during the afternoon session of the pyramid presentation.

Jeanine Ambrosio
CDC Representative
Role Play Exercise

Jeanine Ambrosio (acting as the CBO) and Charles Collins (acting as the Health Department) engaged in a role play exercise in which they received a cooperative agreement to conduct outcome evaluation [See copy of script]. Following their role play, the floor was opened for discussion.

Discussion Summary:

Morning Session

❏   An inquiry was posed as to whether participants should interpret the role play example in the context of the health department trying to select an intervention to satisfy the outcome evaluation requirement in the Guidance. Also, a question was posed as to how the health department would be providing technical assistance to CBOs which might be interested in doing that on their own. Charles Collins responded that the intent of the role play was to model some of the difficult questions that the health department would have to go through in terms of selecting an agency and an intervention for these types of evaluations. Also in the role play, in the end Jeanine Ambrosio (the CBO) asked for feedback. He thought that it would be common for programs to want technical assistance (for example, it may not be that CBOs are afraid of cost-effectiveness analysis per say, but they don't know how to do it and are seeking guidance).

❏ An inquiry was posed as to whether, based on the role play example, they would select outreach (e.g., Are the goals, objectives, and outcomes a program is trying to achieve appropriate for evaluation?). With the short encounters, they weren't talking about behavior change probably. Were they talking about behavioral determinants, or maybe having some effect on perceptions of risk? Charles Collins responded that if, in fact, the objective of the program was purely condom distribution, then the 2-second contact may be appropriate. If the objective was to increase risk awareness, maybe an average of 5-minutes would do that. But if the CBO was really focusing on behavior change due to this intervention, she'll experience problems. She may not be able to get much behavior change for the amount of "dosage" that she is giving people in the street.

❏ A question was raised as to how follow-up, in the case of the role play scenario, would be conducted. The only way the participant saw that it could be done would be to ask the client to voluntarily agree to reveal their identity and to allow them to be contacted in some way on a post basis (1,2, or 3 months down the road by mail or phone) to administer some kind of risk assessment instrument. Another participant responded that the way they're not using names but are trying to do some type of evaluation where they're comparing people – they're using the "Stages of Change" model. On their evaluation forms they're asking people if it's the first time they've been spoken to by an outreach worker. Then they compare the evaluations where people have spoken to an evaluation worker more than once, to those evaluations where people have said they've only spoken to an outreach evaluation worker once. Their hope is that, over time, for those people who have spoken to an outreach worker more than once, they'll see a reduction in risk behaviors.

❏ A participant pointed out that studies showed that without an incentive (cash), follow-up would be difficult.

❏ A representative from Tennessee pointed out that the HIV prevention outreach workers are not the only people out collecting data. Sometimes clients they meet on the streets are confused as to which team they've talked to, so this can lead to the collection of incorrect information.

❏ A point was made that in the role play, only one strategy was used and that more should be planned for.

❏ An inquiry was posed as to whether doing a risk assessment was the intervention, or whether the few minutes that the client spends with the outreach worker is the intervention. If the outreach worker is making contact multiple times, that becomes the intervention. Charles Collins responded that that was what he was struggling with in the role play interview and why he wanted to see how the new workers were trained, because he wanted to learn exactly what the intervention was. Was it the assessment only? Was

there some type of stage-based, tailored, or uniform message given? They didn't really get to the point in the role play of identifying what the intervention really was that took place in the 5-minute encounter.

❏ A suggestion was made that it would be nice to have a "cookbook" format of pre/post measures. Charles Collins responded that Volume 2 of the *Guidance Supplemental Handbook* in the Outcome Monitoring Chapter, has some suggested measures for condom use and for injection drug use as a starting place. They're not the "gold standard" by any means, but they can be helpful. Gary Uhl added that they would have that solidified for directly funded CBOs. That should be finished in approximately a year and a half. He pointed out that participants who'd worked on projects such as the Special Projects for National Significance through HRSA and other funding mechanisms through the federal government where, in the initial stages of a cooperative agreement, those are laid out in the first year. All of the people who are funded collect whatever information they want to, but there is always a core set of common indicators. He said he found that lacking in the previous cooperative agreement for states. This will make it difficult to aggregate data. Moving this process in that direction is slow, but they're starting with the CBOs that were directly funded by CDC.

❏ A participant said that, given the need for correspondence between the content of the intervention and the measurement, if they are given core measures, that requires that their content match those core measures. With regard to the implication for CBOs, CDC was asked to comment on how they would deal with this, particularly since it's very difficult to find outcome measures that can go across interventions. Gary Uhl said CDC would pose a list of core questions that they think would be most appropriate to ask to determine changes in behavior. It would not necessarily be prescriptive for all interventions a CBO would fund, but a common set with which CDC is familiar and can provide suggestions about. There are lots of examples within the HIV/AIDS Division of consensus items and measures.

❏ A participant said that with regard to the Guidance and the recipe on how to do a plan, in the outcome evaluation section, it asks general questions. Obviously, the role play and discussions suggested that CDC wanted something much more detailed than that (e.g., sample size, how did you arrive at it, etc.). An inquiry was made as to what CDC planned to do in 2002 – when do they want the plans?   Marlene Glassman responded that CDC really had no plans to review each jurisdictions proposal, sampling plan, or intervention. That doesn't mean they couldn't give some thought to doing that, but in all honesty, they had not planned on it. What they plan to do in the next week or so is to get a status of outcome evaluation and IRB involvement from each health department – not methodology, design sample, etc.

❏ A participant expressed concern about some of the "objective creep" they seemed to be

hearing. She suggested that everyone go back and look at the purpose in the Guidance of why they are doing outcome evaluation. Her understanding was that it was to increase information availability about the effectiveness of different interventions – not to collect a national standard set of data. If that is, indeed, the point of the jurisdictions doing this, then CDC not becoming incredibly involved in a critique of a proposal and design seems to be asking the jurisdictions to spend money on something that may not ultimately be considered of sufficient quality to enhance the knowledge base. Marlene Glassman responded that the participant was bringing up one of the major questions that distinguishes research from evaluation. CDC's argument has been (Chapter 7) that this is program evaluation.

❏   Participants urged CDC to take a more active role in working with the organizations and health departments to make sure their designs are solid, whether they end up calling it research or program evaluation. Marlene Glassman agreed that they should think about this issue. Charles Collins added that the issue of common indicators or measures would really be to assist health departments in not having to re-create them, but to know that there are some standard assessments. They're not saying that they should be required for all health departments, however. If this does go through as planned, there are regional trainings proposed for the fall.

❏   David Cotton noted that part of the tension in the room was what CDC often heard which is that some people are begging for structure, examples, and things to help them move along while others don't want CDC to come down with guidelines or limiting what they can do. Certainly, that creates a lot of tension and responding to both constituencies puts CDC in a difficult situation.

Afternoon Session

❏   One participant said they didn't know if they would get as specific as the health department did in the role play. He thought it was better to let the CBO just talk, because when the questions get too specific, the CBO is going to respond directly to those choices posed, causing the health department to miss out on key information that would give them a real assessment of the agency.

❏   Another participant pointed out that in many cases, the specifics weren't there, or was there fidelity to a particular model in the role play. For this CBO, things were very flexible in the field, they were doing whatever a particular client needed or whatever the new staff person was able to do, etc. Because of that, it's hard to pinpoint specifics and hold things to a particular model. Charles Collins responded that when they designed the role play, they were aiming for what the typical outreach program was like, and to show the struggles with trying to pin it down.

❏   A participant indicated that they went on visits to their CBOs, and one of the ways they got them to even think about this (they were typical of this role play) was to ask them, "If you were trying to get funding from someone, and had to prove that you were doing something productive, what would you want to know that your agency was doing?" so that it put the onus back on the CBO to think about what they should know. This helped the CBOs create a list of what they wanted to know, because they thought they were doing it, but they weren't sure. This gave them a great opportunity to set the work plan for their year's agenda. They then went back to revise their goals and objectives to reflect putting these pieces in place, which made it an easier transition to evaluation.

❏   One participant expressed concern with sample size in the role play model, and inquired as to how an estimated 100 contacts per month that could range from 2 seconds to about 30 minutes, could produce a large enough sample size to do effective outcome evaluation. Charles Collins agreed, noting that it was one of the things that had happened in terms of the calls they've had from the states asking about appropriate sample size. One of the first things CDC ask the states is to think about the hypothesis and calculation of appropriate sample size. There needs to be enough sample size to answer the hypothesis.

Marcia Sass
Health Department Peer
New Jersey Department of Health and Senior Services

Marcia Sass said that as early as 1994, when the Community Planning Process was introduced in New Jersey, on day one, the consumers within the group demanded that not only should they do process evaluation, but also do outcome evaluation of their programs. So, evaluation has always been a priority in the New Jersey HIV Prevention Community Planning Group, and it was listed as a major priority in the first comprehensive plan in 1994. As soon as they had the opportunity to go for funding in 1995, they did so.

She said that either New Jersey was just lucky, or they were smart, but their populations and interventions have always been behaviorally based. In New Jersey, the leading mode of transmission has been injection drug use, followed by sexual transmission through infected partners. Their plan, populations, interventions, etc. have been based on addressing those risky sexual behaviors. So, they immediately submitted an application for supplemental funds to their 99094 agreement and received funding for a series of programs that came out of Community Planning. The recommended interventions/ services came out of research or effective programs, and the interventions were those that had been studied, and they were designed either to reduce injection drug use or risky sexual behaviors through behavioral interventions.

They launched a program in 1995. They developed a protocol, came up with a set of objectives for both process evaluation across the board on all of their agencies, and outcome evaluation on

their agencies that identified prototype programs/ projects (For example: for injection drug users, for sex partners of injection drug users, and for at risk populations for sexual transmission such as women, youth, and men who have sex with men). They developed a conceptual framework upon which their evaluation has been based. Because everything was being determined behaviorally, they decided that they could use one instrument, and that it could be developed so that if clients didn't participate in a particular behavior, they could skip out of that section.

Some of the things to keep in mind are that, at the state level, they did have evaluation capacity (e.g., people trained in outcome evaluation). The other thing, and this is probably consistent among jurisdictions, is that depending on where they are, the states procurement procedures, and even hiring make it extremely difficult to get the kinds of staff that might be needed to carry out these kinds of activities. They realized early on that they would need to work with a collaborator. Their choices were to get the resources within the division, by working with another department within the Department of Health, go to a sister state agency, or the worst fate – through the Department of Treasury and the procurement system because then Treasury makes the decision on who the evaluator is. They wanted to avoid that, so their choice was to go with the sister state agency. They created a legal agreement that spelled out the collaboration, the requirement for an advisory committee, and all of the deliverables for the particular collaborator.

Marcia Sass said they'd learned a lot as they moved along. They actually received the funding in September of 1995. It took about 18 months to get the agreement in place, and by the time the agreement was in place, it was about time to close it out and start over. That is what they did. They spent about $5,000 to close out the first agreement and start over again working with the collaborator. She noted some of their difficulties:

❏   Countless hours have to be spent training collaborators. Even though well established in their communities and with many having plans, etc. the majority of their staffs are not inherently trained in how to deliver behavioral interventions. Training/re-training was necessary (and time consuming), and this led them to develop a training program, in which all of their staff and agencies are required to participate. The series includes 17 days of training, of which behavioral training is a major component. Still, turnover is rampant amongst both staff and interviewers. Training and retraining of interviewers has been necessary.

❏   Based on the amount of funding they received, they immediately had to scale back on the evaluation, and that included having to scale back on specific comparison groups. Since then, they learned that unless they'd done a full randomized control trial, there wouldn't be any comparison groups for the particular clients they have that would have given them any true association.

❏   There were no instruments to assist them to do the measurement. They combed the literature and built an instrument that would enable them to assess the outcomes. It took

an enormous amount of time to put that together. To do the Stages of Change and Transtheoretical models, most of them are scaled items with anywhere from 24 to 40 items. This would have taken three weeks to do a baseline if they'd incorporated all of the elements that were there.

❏   They were always working on buy-in at the state and community levels. They wanted the community level input, because they thought it was critical, but this was labor intensive. They needed to know if there was longer term improvement. So, they tried to study baseline and 6, 12, and 18 months after they'd enrolled in the program. After years of work, they have baseline and three follow ups documented.

❏   They also identified early on that they would need all of their instruments, anything associated with the instrumentation (e.g., the consent forms, hand cards, incentive receipt forms) in Spanish. That was an incredible challenge. It was difficult enough putting it together in English.

❏   They created training and coding manuals for each one of the interview schedules, which was also time consuming.

She noted some of their lessons learned/recommendations:

❏   Consider the real intents of doing evaluation, and how they translate into evaluation goals and objectives. New Jersey was specific, and they were never out to establish causality. They were looking to see whether they could identify *anything* that might be due to programs, and to build in program improvements.

❏   Buy-in is necessary at all levels. They've had more buy-in from their community folks than they have had at the state level.   This is an unceasing activity.

❏   Evaluation is clearly dependent on the resources available. They can't do something like this without resources.

❏   They had enough time to assess their agencies by the time they went into the field. No matter how well their agencies were established in their communities, they are moving targets. There is churn, flux, chaos. They're stable one day and not the next, even if they're trying to implement the same intervention over time, particularly with behavioral interventions where so much of it is how an individual relates to a client.   They also learned that even though their agencies were very well meaning, and they really wanted to do follow-up interviews, when it was time to do the follow-up, they weren't there and collaborating evaluato staff had to take over.

❏   Maintaining client confidentiality and privacy is a critical issue. They had to go to each

agency to ensure that there was space, etc. to make sure there would be privacy. The questions are fairly intrusive, so this required constant training and re-training to ensure that confidentiality/privacy issues were appropriately dealt with.

❏ What design will best fit is an issue in terms of evaluation goals and objectives. They have to determine what the emphasis should be (e.g., the process, process monitoring, evaluation, or impact – or all of those things).

❏ Not every evaluator can do program evaluation, and there aren't a lot of people who have any concept of how to go about doing this.

❏ Procurement procedures are a constant issue.

❏ They must realize that they can't please everyone all of the time. Their internal customers have been much more difficult to please than their agencies.

Discussion Summary:

Morning Session

❏ An inquiry was posed as to who pays for the 17 days of training. Marcia Sass indicated that the state health department pays for it.

❏ A number of participants were interested in obtaining copies of New Jersey's survey instruments. Marcia Sass responded that she would look into doing that. She said that part of the difficulty in getting the instrumentation done had to do with computer capacity, but there were periods of time that it was almost impossible to work on the instruments. Thus, it was unclear whether they would work on a website, etc.

❏ Noting that Rutgers was listed in Marcia Sass's materials, an inquiry was posed as to what role the scientific community plays in this, and what their role would be in the future (e.g., Would Rutgers publish the information?). Marcia Sass responded that the academic community provided a fair amount of information through the advisory committee, and both the department and Rutgers had opportunities to identify experts in sampling, research design, etc. The department also has very specific protocols in terms of what happens with the data and how it's presented, etc. They have in their work product statement specifically what the collaborator can do with the data. While the department will be working with Rutgers, they can't publish without the department's reviewing the information first and having the opportunity to have their names listed or provide disclaimers as to what's in there.

❏ With regard to Marcia Sass noting that she had more buy-in from the community than the

health department, others said that was their experience as well. However, when it came down to actually doing the work, it was hard to get enough community involvement, participation, and dedication throughout the length of the process. Participants also wondered what New Jersey's mechanism was for reporting results back to the community. Marcia Sass was asked to comment more on that. Marcia Sass indicated that they have a wealth of data that covers many things. It takes a while to clean and analyze the data. They have engaged the agencies over time. About every six months, they have re-training retreats where they bring everybody together to discuss issues, problems, and give them specific training in various areas. These have been very helpful. They will soon conduct de-briefing sessions with each one of the agencies. This will be done one on one, and they will provide data and feedback.

Afternoon Session

❏   An inquiry was posed as to how long the implementation took. Marcia Sass responded that they started in 1998, and their delays came in the ability/inability to enroll sufficient samples sizes. This is one of the problems with trying to do comparison groups. They actually closed out baselines in December of 2000, and some of the agencies actually never made it to their targets.

❏   An inquiry was posed as to how large her staff is that's dedicated to this. Marcia Sass responded that her staff included herself, one person for the process monitoring/process evaluation side, she has two vacancies that she has a lot of difficulty filling, and she has a lot of outside support. Having a collaborator has been essential for her.

❏   A participant stressed that they should all work within their departments. Health department staff must buy in because this is a painstaking, long process.

Roger Myrick
Health Department Peer
California Department of Health

Roger Myrick said that California is an interesting place to do HIV work because from the very beginning of the epidemic, they've had a lot of different constituents come together to put pressure on state legislators to provide funding for AIDS research. The program for which he currently works, which is affiliated with the University of California (the Universitywide AIDS Research Program – UARP), was formed in 1993 in response to activists, researchers, politicians, and educators across the state putting pressure on the state legislature to create some type of funding mechanism to provide dollars for AIDS research in a variety of areas (e.g, basic research, clinical research, and social behavioral research).

In 1995, things became more heated in terms of social behavioral research in California largely

because activists were coming to the legislative table and pointing out the fact that UARP was not providing an equitable amount of dollars to social behavioral research. In response, the agency (UARP) designated and created a funding mechanism that provided dollars for a community collaborative prevention evaluation research that would fund partnerships between researchers in California, either at University of California research institutions or at non-profit research institutions, to partner with community prevention service providers to evaluate preventions or to study populations at risk who were receiving intervention services.

So, California is in a unique position because early in the epidemic, even before federal funders began to get involved in this issue, California took steps to create the basis for an infrastructure that would provide an on-going support basis for prevention evaluation research. In 1998, that program took a very important step in developing a partnership with the State of California, in the Department of Human Services State Office of AIDS. In the state office, they were preparing for the release of CDC's Evaluation Guidance. So, they were particularly interested in UARP's community collaborative program because they saw it as an opportunity to frame the entire Evaluation Guidance not only for CDC, but also for the State of California as a community collaborative response. In terms of community planning, that might be the most obvious first step, but also it is a first step in terms of developing process measures and ultimately moving to more outcome monitoring and outcome evaluation strategies.

One result of the partnership being formed in 1998 was that his position was created. It is a liaison position between the university system and the state health department system. It's an unusual type of job in that he's not supposed to be in either camp too much, and in both camps equally. While his home base is in the university system, the success of what he's doing is determined by the extent to which he can bridge those two communities that often have very different goals.

Given that context and framework, he discussed what they're doing in California to implement the Guidance and what they're doing in terms of outcome evaluation. The funds that they're receiving from CDC are primarily being used for infrastructure. The money they're using for outcome evaluation activities are coming from the State of California. So, they don't run into the kind of problems that have been brought up by the recent IRB development.

One of the first things that California did was to create, in the Office of AIDS Prevention Branch, a Prevention Research and Evaluation Section that was devoted solely to developing and implementing not only the CDC version of the Guidance, but also to addressing the statewide needs regarding evaluation. The second step was the collaboration with the University of California. Run out of the university president's offices, they are broader than any of the individual campuses. That's important because what they see with this collaboration is a collaboration between two statewide systems that then has impact on the more local health jurisdiction level.

The next step that was critical was to get input from stakeholders which they did through a series of expert and stakeholder input meetings that included representatives from health departments, CBOs, and community planning groups from across the state, and prevention evaluation experts (across the state and nationwide). They called upon these people to assemble an action plan for key evaluation needs, concerns, and potential strategies.

The next step was to develop a state-specific guidance, largely based on the CDC Guidance. At the same time, they began to develop their web-based reporting system which will collect data on process implementation, and eventually on outcome monitoring. The system is being set up so that outcome monitoring will be an option in the future, but in order to get the system up and running in a timely manner, they're not able to have those fields immediately.

One of the things that is happening in California, and probably in many other states, is that local jurisdictions are currently collecting outcome monitoring data. As with their process implementation data, it's been coming in in narrative forms. It's impossible to do anything with, or even to ever really read. So, one of the things that the Evaluation Guidance and the web system is allowing them to do (and forcing them to do) is to systematize their data collection in terms of process and outcome monitoring.

In 1998, they also developed a plan for strategic technical assistance. Unfortunately, that plan didn't function well. They have now gone to new contractors in 2001. That is an on-going struggle, even in a state that has devoted many resources to this activity.

With regard to their outcome evaluation projects, even though all of them have a pre/post component, what they were primarily interested in in these project (because they were bringing together researchers and community providers) were projects that would be defined as outcome evaluation research – there is some type of comparison group. For all of the projects that they fund, they always require that the university or research institutions obtain IRB approval – even if it is a more simple pre/post design.

They essentially initiated a series of RFA processes that involve researchers, evaluators, health departments and CBOs statewide. The RFAs have been developed and coordinated through him and their partnerships with other stakeholders across the state, as well as nationally. Part of this effort involved statewide communication with all of their HIV prevention providers and researchers at the local level. So, it was a fairly major undertaking. They wanted to involve everybody in the process, so after each RFA was let out, they conducted statewide information sessions traveling around to different parts of the state to explain to people who might be interested in applying what the RFA was about, and the kinds of things that they needed to do in order to be successful.

A lot of this effort involved relationship building – identification of the players, who might be interested in this kinds of activity, who the potential collaborators would be, and getting the word out to them. Even more than that was the process of helping people make connections with people they might not have thought about. One of the things he did, primarily through large listservs, was to help link people in different geographic areas of the state with researchers who might be doing work either with similar populations or in the same geographic area. This seemed to be a particularly important piece depending upon the specific RFA.

Part of the preliminary work involved a lot of information dissemination in terms of literature about outcome evaluation, the CDC Guidance, the kinds of things that they were looking for in terms of outcome projects. So, they provided this general guidance up front, and they had a lot of characteristics in the RFA of collaborative activities that were required. Beyond that, a lot of the issues that came up earlier in terms of designating design, sample size, retention/recruitment strategies, etc. was left up to the researchers and the community partner to determine depending upon what worked best for them.

He thought there were advantages and disadvantages to both a more controlled effort and a less controlled one. It makes a lot of sense to let researchers be in charge of research design, but if too much freedom is allowed, then they get projects into the field that, even though they've had community input, once they're up and running then they start to deal with difficult issues like recruitment/retention that can fall apart. They've certainly had to deal with that.

One interesting thing about their review process is that their review committees are comprised of 50% academic researchers and 50% community service providers. Often in HIV research review committees, what they have is largely a research committee with community input. So, there will be 2 or 3 slots out of a 10-member panel who are determining how dollars are going to be awarded. Their set-up was very different because they had the 50/50 split, and they really see in their reviews that projects will come in with beautiful, elegant designs with which one could cut glass. However, they sounded very top-down and as though they didn't have the community input that they needed. So, even though they were beautiful and sound in terms of science, because the review committee was made up of 50% providers, they ranked as some of the lowest in the funding.

In terms of characteristics of the RFA, he likes to think of them as their principles of collaboration. They require documentation of these in the proposals that they receive from researchers. These projects were set up with dual principle investigators – one from the research organization and one from the community provider organization. Both people have equal amounts of power, and they get to determine budgets, so they didn't always get equal amounts of funding. What tended to happen is that the research organization got more funding.

However, in terms of determining the evaluation design, the use of the data from the evaluation, how the evaluation will actually be managed and run were all collaborative decisions for which they require documentation in the proposals.   He reviewed some of the types of evidence they required in the proposals to ensure that people weren't only *thinking* as an equal and collaborative team, but that they had to evidence that they were *functioning* in that way – even prior to funding.

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Some of the additional requirements included the following:

❏   All projects must focus on high priority populations for the state (largely MSM in California – 75%)

❏   Documentation of implementation, outcomes, on-going collaborative activities, and on-going status of community infrastructure (staffing, stability, training).

He developed a dissemination plan to take information from these project and distribute that information to all health departments statewide. The components or elements that he is collecting from the projects include information on:

❏   Core elements of the interventions that were administered
❏   Core elements of the research project that were the foundation for the research activity (e.g., research protocol, instruments)
❏   Description of the necessary community organization infrastructure that had to be in place in order for the intervention to be successful

He is in the process of collecting this information now, and they should be able to disseminate that to the health departments across the state beginning in January, 2002. The difficulty lies in tailoring that information to make it relevant for other health departments, and ensuring that people aren't using other instruments for interventions that the instruments shouldn't be used for. That's something that they're in the process of dealing with.

They also have all of the grantees form a consortium that comes together twice per year to address issues that relate to community research needs. This has been a very interactive group, and one that's really helped move their process forward. They currently have 20 projects that are evaluating a variety of interventions, and a variety of populations. All of the projects that were funded from 1999 on have some type of control and/or comparison group. That's an essential part of the study. He said that it's unclear to him how successful the projects that started in 1999 are going to be. He thinks in a lot of ways they'll be very successful in terms of documenting some of the community information they need to get from these projects, but in terms of being able to say which piece of the intervention works with which type of population – he thinks they're going to be mixed results. The projects will probably be able to make some claims about which parts of the intervention worked, but he doesn't think their sample sizes in the end are going to be large enough to be able to say which pieces worked best with which types of populations within the studies. In conclusion, he shared some materials with the participants.

Discussion Summary:

Morning Session

❑   A request was made for Roger Myrick to give them a sense of the typical time table and amount of funding for the outcome monitoring and outcome evaluation projects. Roger Myrick responded that these are typically 3-year projects. Funding varies depending upon what kind of infrastructure there is for the organizations because the health departments and the research infrastructure help support that to different degrees for different institutions. One project is being funded for $500,000 for the entire 3-year project for both partners. That's a fairly small project. Another is funded for 3 years at $900,000 and that's being shared between two partners. In that instance, that money is going to two organizations that have less infrastructure than other organizations. Their dollars were higher to compensate for that. It's about a $2 million dollar a year program.

❑   An inquiry was posed as to whether Roger Myrick's collaborations always included a University of California school. He responded that it did not have to. They have state schools and PIs from non-profit research institutes as well. The thing they can't fund are privately funded researchers. They can come on as consultants, but they cannot be the main PI for the project.

❑   An inquiry was posed as to whether a health department could be a main PI on a project. Roger Myrick responded that they could, as could a person who is in an executive position at a CBO.

❑   An inquiry was posed as to whether, when considering the State of California, they excluded Los Angeles and San Francisco, given that these are considered separately by CDC. Roger Myrick responded that they did not exclude those cities. He said that even though Los Angeles and San Francisco are directly funded by the CDC, they also receive state funds, so they're very much a part of the state system both in terms of the university and the health department structures.

❑   An inquiry was posed to either or both peers as to whether they'd found behavior change. Marcia Sass responded that the primary role of their collaborator had been for the fielding and quality assurance, and not in terms of the analysis. They were trying to get on board, within the department, someone who was really skilled in that particular area. It's been an impossible situation. They now have a consultant who is skilled and trained and will be working with the collaborator and the department so they will finally be producing some of the data within the next couple of months. Roger Myrick added that one thing they've learned is that this whole process has involved, and is leading them to, a total re-conceptualization (from both the research and health department perspectives)

of what evaluation means in terms of service provision. They're having to re-educate both parties in order to bring people to common ground to make these efforts sustainable and to make them have any kind of long-term impact on the community or organizations in terms of research infrastructure. In thinking about TA, one of the things they've had to focus on is that they're not just teaching people to use reporting systems. They're orienting people to the activity of program evaluation and how it can help support their programs.

Afternoon Session

❖ Gary Uhl said that this programs seems to him to be very unusual, in-depth, and very interesting. However, he thought that it in no way supplanted what health departments are required to do regarding the Evaluation Guidance – this is above and beyond that. Roger Myrick responded that it was above and beyond Guidance requirements.

❖ An inquiry was posed as to how much the total award amounted to, or a projected cost, particularly given what appeared to be a very large staff and that these projects are long-term. Moreover, the epidemic is constantly changing.

❖ Roger Myrick responded that in terms of dollars, they're at the height of their funding, and are letting out about $2 million per year in projects. That will go down. The projects typically run 3 years each. In terms of what the projects will be able to tell them, he said he thought that even with the difficulties that all of the projects have encountered with recruitment, they will be able to reflect that specific parts of interventions do or do not work to achieve certain kinds of change. He didn't think they'd end up with large enough sample sizes to be able to tell which changes work with which groups the best. Depending on the target population for the project, that may or may not be important. If there is a very homogenous group, this may be less important. But, in most cases, they have groups looking at at least 2 to 3 types of target populations that are related in some way. Regarding staffing, he really is the person who staffs it, he has one full-time research associate, and then he has pieces of people in the university and the health department.

❖ An inquiry was posed as to what percentage of the $2 million came from CDC and what percentage came from the state legislature. Roger Myrick responded that the majority came from the state. In the beginning, the CDC money they got for supplemental projects jump-started the project and gave them some dollars for infrastructure. However, in terms of the actual research projects themselves, depending on the nature of the project, probably 75% of the funding comes from the state legislature. He acknowledged that he needed to look for additional sources outside of that, such as soliciting other federal funders like NIH to support that. He stressed that it was critical not to look to one funder to provide resources for such a resource-intensive activity.

❖   A participant from Texas indicated that they and their evaluation partners are rapidly trying to do some extractions of the current literature to look at the core elements. He wondered if Roger Myrick had come up with a standardized taxonomy in terms of standardization of the core elements. Roger Myrick responded that they had not. With their dissemination plans, they have included the general materials that they want from the sites. As they begin to go around to the sites to collect these details, the sites will make these determinations for him.

❖   Several participants complimented the materials and program, but pointed out that in reality, in a number of rural states, programs would be lucky to get two trainers to actually follow the same protocol, and come up with a minimal number of clients. With that in mind, an inquiry was posed as to whether CDC had considered letting small to medium capacity states do a multi-site trial for one experiment in order to solve resource and other problems. Charles Collins responded that CDC would be very open to all types of creative activities, particularly if it turns out that they cannot use funds for outcome evaluation.

Gary Uhl
CDC Representative
Closing Exercise

Gary Uhl said the panel thought a good way to close the session would be to make a brief list of concrete, key issues which much be considered when conducting an outcome evaluation that they might want to tell their co-workers, or other people when they got back to their jurisdictions. The list included the following:

❏   What are the real intents and how do these translate into evaluation goal(s) and objectives?

❏   Whose buy-in do you need and how do you get it? Getting true buy-in for evaluation is an ongoing process at all levels. This includes providing and receiving feedback.

❏   Evaluation is dependent on what resources are available.

❏   Many of the agencies funded to implement HLV prevention interventions are "moving targets." Chaos is common. Not only are the clients transient, the staff are too. Program staff (and clients) you work with in the beginning may not be the same by the time you start your evaluation and/or finish it. Even if the stated interventions do not change, who is delivering them is likely to. A lot of flexibility is needed. If staff/community members are engaged to do the evaluation, the evaluator needs to be able to "jump-in" and continue on with the activities when they become overwhelmed.

❏   What language(s) are needed in the data collection instruments must be considered.

❏   How client confidentiality and privacy can best be maintained must be addressed on an agency by agency basis.

❏   What design will best fit the evaluation goals and objectives?

❏   Determine where the emphasis should be on inputs/process, outputs/impact or all?

❏   How do you select an evaluator? / Who should do it and how should you relate? A collaboration often is needed. Don't assume that all evaluators are capable of accomplishing outcome evaluation.

❏   Determine how your jurisdiction's procurement procedures work to provide you with the greatest flexibility in selecting an evaluator.

❏   Realize that you can't please everyone all the time, in particular those internal customers who need instant gratification (immediate data). Outcome evaluation can take time. Changes in the design and other evaluation activities are often needed. Stick with it.

End of Summary Proceedings
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